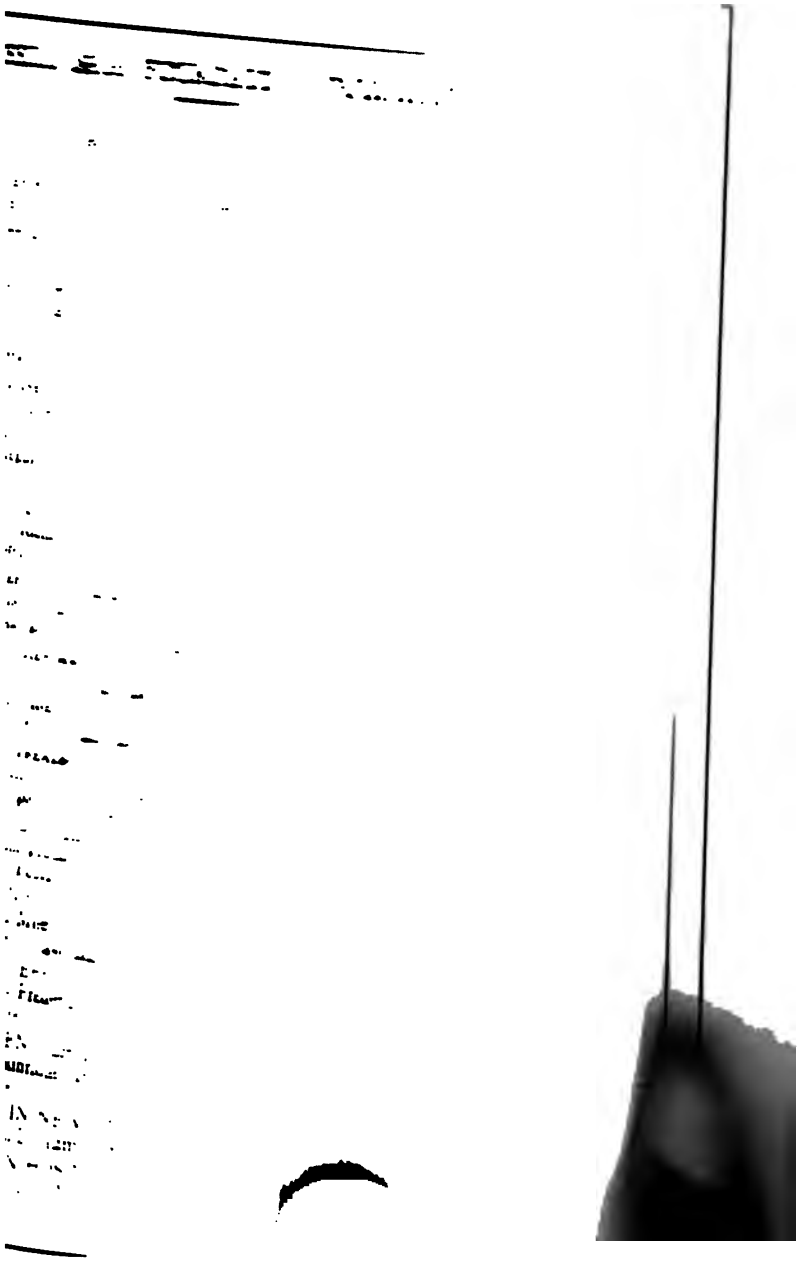
SOCIAL WORK IN HOSPITALS

CANNON



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SOCIAL WORK IN HOSPITALS

A CONTRIBUTION TO PROGRESSIVE MEDICINE

BY

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To Dr. Richard C. Cabot
whose insight, constructive imagination and fearless pioneer spirit have been the chief factors in starting and bringing to its present status in this country, organized hospital social service.

PREFACE

IN THE winter of 1912 I had the interesting opportunity of visiting most of the hospital social service departments in this country. At that time I was impressed by the variety of types of organization, by the diversities in the interpretations of the hospital social worker's function, and by the great need for more adequately trained workers. In every department the paid workers were women. It was interesting to note, however, that in some instances men—especially medical students—were being drawn into volunteer service. I was even more impressed with the widespread interest that I found among physicians, hospital authorities, and lay people, in this new conception of the hospital's social responsibilities. If hospital authorities and physicians are persuaded that social work is needed as part of thorough treatment of the sick, surely the workers, in spite of their handicaps in training, in spite of the lack of standardization in their case work and in their organization, are meeting, nevertheless, a real need. Every department I visited seemed to me pervaded by a genuine spirit of service. Eagerness for information concerning all phases of the hospital's social problems was also

notable among those actually engaged in the work. This very general desire and evident need for exchange of experience and for a more conscious and consistent effort to establish standards, has made it seem worth while to present this preliminary survey of the present status of hospital social work.

Suggestions have come to me from workers in various existing departments and from an interesting personal experience. To make acknowledgment to all who are responsible for material presented in this book would be impossible. The material has come to me in some instances unconsciously, but more often with the most generous spirit of helpfulness from hospital social workers, from physicians and institution executives, and also from many other friends of social service,—among them the patients themselves.

I am indebted to my sister, Cornelia James Cannon, and to Miss Elizabeth V. H. Richards, Head Worker of the Social Service Department of the Boston Dispensary, with whom many of the subjects in this little book have been discussed.

Especially am I under obligation to Dr. Richard C. Cabot, whose stimulating leadership I have enjoyed for six years. He has read the manuscript and made invaluable suggestions. I am indebted also to Miss Mary E. Richmond, without whose stimulus and interest the book would not have been attempted.

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CHAPTER I

INTRODUCTORY

THE hospital social service movement aims to throw a new light on medical practice in our institutions. It seeks to understand and to treat the social complications of disease by establishing a close relationship between the medical care of patients in hospitals or dispensaries and the services of those skilled in the profession of social work. It strives to bring to the institutionalized care of the sick such personal and individual attention to the patient's social condition that his recovery may be hastened and safeguarded.

The physician recognizes physical symptoms and seeks for the underlying causes of disease. The skilled social worker recognizes social symptoms of human distress and also seeks their underlying causes, that she may the more wisely help. Our large charity hospitals and dispensaries shelter many who need both kinds of aid. The services of doctor and social worker then become interdependent, just as the physical and social conditions of the patient himself are interrelated. This interdependence of medical and social work, not only in treatment but also in seeking for causes of

disease, the hospital social service movement is emphasizing. It seeks to find the common ground of medicine and sociology and to relate most effectively the functions of the doctor and the social worker.

As a cause, and also as a result of social distress, disease is a large factor in the plight of those who become dependent on public and private charity. Mr. Devine says* that inquiry into the physical condition of members of the families that ask for aid—without for the moment taking any other complications into account—clearly indicates that either as the chief cause or as a complication due to the effect of other causes, "physical disability is . . . a very serious disabling condition at the time of application in three-fourths . . . of all the families that come under the care of the [New York] Charity Organization Society." Thus the lessening of disease is of importance not only for health and comfort, but for economic welfare and social progress. This fact makes hospital social service a particularly significant feature of constructive social work.

As hospital problems are social as well as medical, two expert professions, not one alone, are needed. Yet only in the last few years have the medical and the social worker been able to aid each other. Only within that period have they been able habitually to meet as experts, each

* Devine, Edward T.: Misery and Its Causes, p. 54. New York, The Macmillan Co., 1909.

teaching and each learning from the other: both united to serve the patient and the community. Both groups must recognize a common ground before they can reach a mutual understanding. So we find gradually developing this sympathetic interweaving of effort by two professional groups that for a time struggled separately with the problems of the sick and dependent in the community.

Since the beginning of the hospital social service movement in 1905 there have been started in the United States over one hundred social service departments in hospitals and dispensaries. Extensive as the interest has become we are not, after so short an experience, justified in dogmatizing about either the function of the hospital social worker or the proper organization of the work. We are still pioneers. Our field is only beginning to be surveyed. All the experience gathered so far must be considered as experimental material. Nevertheless, out of it we may at least develop some ideals. A few fundamental principles have been evolved. Not only has it been demonstrated that medical and social interests are closely interrelated, but also their technique, —neither can reach a high quality without similar excellence in the other.

The social worker may destroy the value of a doctor's prescription by a faulty social diagnosis or treatment, and a doctor may no less effectively vitiate an excellent social diagnosis or treatment.

A patient for whom a back brace was ordered by an orthopedic surgeon was found subsequently by a social worker to be starving herself to pay for the brace. Later a general physical examination showed that she was suffering from pernicious anemia. One thing is certain: a patient with pernicious anemia does not need to starve herself for a back brace; she will die soon enough without that. Another patient, markedly debilitated, came to the hospital for a tonic, but received little benefit from the physician because she was struggling to care for herself and young son on the $4.50 a week provided by a relief society.

Between the two extremes there are many dangers of ineffectiveness in what is being done for the patient or with the patient, if a high standard of work is not sustained. Not every hospital can make the most effective use of the medical-social worker even though the latter be an expert. *For if the social worker is to help make treatment effective, good medical work is the prime necessity.* If medical diagnosis is vague or faulty, no social work, however expert, can compensate for it. Hospital social service, as part of efficient medical practice, can develop, therefore, only in institutions where the medical work is really and constantly of a high grade. In short, to be effective, medical-social work demands two things: constructive medical work and constructive social work.

In the pages that follow an attempt has been made, not to present a text-book on hospital social

work, but to offer an interpretation of what the movement means to some of those most closely in touch with it. This is no time for dogmatic statements. The essential thing for any new movement is that its leaders, while firm in the conviction that a fundamental truth is being carried forward, should still be open-minded and plastic enough to fit it gradually into its place of greatest usefulness.

CHAPTER II

THE BEGINNINGS OF HOSPITAL SOCIAL SERVICE

THE spirit of service to the sick is not new. Indeed, the care of the sick has been an unfailing expression of human kindliness since the dawn of Christianity. Early in the Christian Era, the care of the bodies as well as of the souls of men was recognized as a duty of the church. Hospitals were established and nursing orders arose as a practical expression of the religious zeal that glorifies unselfishness. Victims of sin and suffering were sought in their wretchedness and served with tender, sympathetic devotion. Throughout the history of hospitals and the history of the Christian Church the spiritual welfare of the sick has claimed the attention of the clergy, and no hospital today is without their ministrations.

In our modern hospitals also there are many persons who recognize that the patient's needs are not entirely physical, and who contribute their share of cheer and comfort to the sick. Volunteer committees of women have for many years visited patients in the wards of various institutions and

extended their friendly offices. Busy doctors and nurses have done countless unrecorded acts of kindness not demanded by the requirements of their professional duties. Thus, the patient's spiritual needs and his dependence on sympathy and affectionate interest have long been recognized both in theory and in practice.

There are, however, some fundamental differences between these intramural attentions and the hospital social service which we are to consider. Formerly, neither the priest nor the friendly visitor co-operated closely and constantly with the doctor inside or with the social workers outside the hospital. It has remained for the medical-social workers of the present day to supplement the function of the unofficial visitors with a fuller consideration of the patients' needs, and with a form of service that is now accepted as an important element in thorough medical treatment.

Four important contributions have been made to the development of this new hospital social service, which, however, is quite different from any of them: first, by the society for the after care of the insane in England; second, by the lady almoners in London hospitals; third, by visiting nursing in its various forms; fourth, by the methods of social training given medical students in the Johns Hopkins Hospital.

The first of these contributions dates back to about 1880. The problem of the insane is a peculiar one, yet the principles on which the after care

of the insane was developed in England are of more than ordinary significance to general medical-social service. The object of the English organization known as the Society for After Care of Poor Persons Discharged Recovered from Insane Asylums is to arrange for the care of discharged patients,—especially those who are homeless,—and to keep friendly oversight during the process of their readjustment to community life. This was always done in close co-operation with the medical superintendent of the asylum. The excellent work of this society was the stimulus for similar work in connection with the New York state hospitals for the insane. The sub-committee on the after care of the insane, of the State Charities Aid Association of New York, was formed about the same time that the hospital social service movement started in this country. The work of this committee has been of such value that the plan has been adopted in connection with hospitals for the insane in many other states.*

The second and probably most important contribution to hospital social service comes from the reorganization of the work of the lady almoners by Mr. C. S. Loch of the London Charity Organization Society. The almoner is an old institution in many of the English hospitals. Mr. Loch saw possibilities of increased usefulness in the almoner's function and presented his suggestions for a new

* See State Charities Aid Association of New York, Fourteenth Annual Report, Nov. 1, 1906. Also later reports of its Sub-committee on After Care of the Insane.

interpretation of her work in a paper published in London in 1892.*

"People talk of medical charity as if it were a thing apart, unlike all other forms of charity, to be regulated by no principles, to be bettered by no co-operation with others. . . . What more glaring picture of charitable impotence is there than that destitute persons should constantly apply to a free dispensary for drugs which cannot benefit them if they lack the necessary food? Or that, in the same illness they should go from one out-patient department, free or even part-pay dispensary, to another without any heed being paid to their actual conditions? To be effectual, even to be equitably administered, medical charity must act in alliance with general charity. Their cause is one. Their difficulties are very similar. Each will succeed better with the help of the other."

How to prevent the abuse of medical charities by those able to pay, has long been a puzzling problem for hospital boards and social workers. Mr. Loch saw in the almoner a means of checking that abuse. But in practice the lady almoner's function soon grew to be much wider than that of mere "inquirer." The first lady almoner was appointed in 1895 at the Royal Free Hospital in London in accordance with a plan outlined by Colonel Montefiore and Mr. Loch in 1890. Their

* See *Nineteenth Century*, Vol. XXXII, pp. 303–304.

plan as presented to the Select Committee of the House of Lords in 1890 was as follows:

"There should be appointed in every medical charitable institution a distributer or referer of patients, who should see the patients after they have been seen by the medical officer, and who, subject to the requirements of the hospital from the point of view of medical instruction or gravity of illness, should decide as far as possible on the statements of the petitioners for relief, and also as a rule, by a reference of the case to a charity organization committee or some proper local organization."

The lady almoner was then to decide whether the patient's social condition indicated that both medical and social relief were more suitable under poor law provision, or whether he had best be cared for at the private hospital to which he had applied, or whether he ought to provide for himself by going to a private practitioner. "On this plan, each applicant at the hospital would receive relief on his first visit, if necessary; medical requirements, from the point of view of education, would be met; the social circumstance of the patient would be taken into account, no less than the medical; and other than medical relief would be forthcoming for those that require it."

In England the hospital was conceived as a link in the chain of charitable institutions and organizations, and the lady almoner was regarded as the expert ready to bring to the hospital problems a

knowledge of the community resources and a mind trained in the methods of social work. The lady almoner has been described by the secretary of a London hospital as "a lady who has had a period of training in social questions generally, and especially in the various organizations of charitable help. She knows all about Labor Bureaus, Emigration Societies, Sick Room Aid Societies, Prevention of Cruelty to Children Societies, Discharged Prisoners Aid Societies, Home Nursing Associations, Convalescent Homes, Societies for the Prevention of the Spread of Phthisis, Provident Dispensaries, Poor Law Infirmaries, Apprenticeship Associations and so on."* In 1905, the year in which the first social service department was established in the United States, many of the London hospitals had the services of the lady almoner.

It is difficult to measure how much the work of the visiting nurse in all her varied services has contributed to the hospital social service movement. She was an accepted part of medical care in the homes of the sick poor long before the type of hospital social service which we are considering was established. Though trained in a hospital, she found visiting nursing so different from what she had learned in the hospital wards, that she was more and more in need of social knowledge. Her function was first conceived as distinctly medical;

* *British Medical Journal*, Feb. 5, 1910.

but she has been forced to add much social knowledge to her medical training.

The form of service which most resembles hospital social work—though it is quite distinct in function—is that of the visiting nurse attached to a hospital and a dispensary. Sometimes the nurses visit dispensary patients or those who are discharged from the hospital, in order to extend or finish the medical work of the institution. Many general hospitals and maternity hospitals, as well as tuberculosis dispensaries and milk stations for babies, maintain visiting nurses for this type of work. Not only in connection with dispensaries and hospitals but also with social settlements has the visiting nurse found a useful field of service.

Somewhat different in its purpose is that form of visiting nursing typified by the extramural work done in connection with the nurses' training school at the Presbyterian Hospital in New York, and designed to broaden the training of the nurse. In 1904, student nurses attended by an instructor began to visit the homes of the hospital and dispensary patients and were "taught to give nursing care, to improve hygienic conditions, and to aid and encourage the patients by kindness and helpful advice." Thus, patients who leave the hospital while still needing surgical dressings are kept under supervision. Tuberculous patients, sick children, and others receive hygienic instruction and are kept in touch with the dispensary physicians. With an increasing recognition of the need

for social work in connection with this medical service, a special nurse was appointed in 1907 to supervise the social aspects of this part of the nursing instruction. This course in visiting nursing is elective and the term of service is two months.

The visiting nurse during the last fifteen years has helped to demonstrate the value of extending the services of the medical institution into the home. As a result of her struggle with such problems as tuberculosis and infant mortality, she has also helped to call attention to the common field of the medical and the social worker.

The most significant contribution to the early development of hospital social service in the United States was made by Dr. Charles P. Emerson, who in 1902 organized a group of medical students for social training. He recognized that truly effective medical training must include an understanding of the background of the patients' lives and something of their standards of living. Dr. Emerson describes the development of his work as follows:*

"It was partly to aid their education that seven years ago (1902) some of the medical students of the Johns Hopkins University organized the first student board of the Charity Organization Society of Baltimore. They visit one poor family or at most two families, assigned them by this society, for weeks, months, or even for four years. They do what they can to improve conditions in those

* Emerson, C. P.: A Social Service Department of a General Hospital. *National Hospital Review*, Mar. 15, 1909.

households. No effort is made to select for these students, families in which there is sickness. The students learn how the poor man lives, works, and thinks; what his problems are; what burdens he must bear. They learn the intimate relationship between the ills of the physical body and the home environment. They also learn how easy it is to give very good advice which will add burdens which cannot be borne. They find out that the poor man is not always a self-convicted sinner nor a self-confessed ignoramus, and that he has his own ideas as to the necessity, and especially as to the possibility, of his following advice. The poor man loves his vices as truly as does the rich man, and will not abandon them at the off-hand suggestion of a strange doctor. The students find that to effect a much needed reform, e. g., to keep the windows open, they must win first the confidence, next the love of the poor patient, and then stick to him closer than a brother to prevent relapses.

"In five years there were on the rolls of active volunteer workers of the three students' boards over sixty students, or one-quarter of the entire enrollment of the school. They do not meet in the hospital but in the offices of the Charity Organization Society. The reason for this was that every member of the self-appointed committee which guided this work was connected with the hospital and was also a manager of the Charity Organization Society; hence no conflict between

these two interests could arise. All the patients at this hospital who seemed to need special social service were referred directly to this society, but the most interesting and the best cases for the students to study are not these medical cases. This organized student work, with its purpose of training doctors in social service is, we believe, a very important department of the hospital."

Dr. Emerson's valuable work differed from the present social service in hospitals in that he was aiming to educate medical students, not primarily to serve hospital patients. His students visited many who were not sick and paid no especial attention to the clinics.

These four expressions of social interest were to be found in varying degrees in many hospitals previous to 1905. That year, however, saw the first organization of a social service department in a dispensary and the beginning of the present spread of enthusiasm for trained social work in medical institutions in the United States. It is well known that to Dr. Richard C. Cabot of Boston is due the credit for introducing the social worker as a factor in hospital and dispensary treatment. Not alone for the sake of the patient's spiritual welfare, not for the training of medical students, nor for the instruction of nurses, nor simply for the extension of medical care into the homes was this form of work created. Rather was it conceived by a physician who, in seeking the improvement of dispensary practice, found in the

social worker a potent means for more accurate diagnosis and more effective treatment. Miss Garnet I. Pelton, the pioneer hospital social worker, helped to lay the foundation of the first social service department,—that at the Massachusetts General Hospital.

Hospital social service as we are to discuss it in this book brings into consideration a worker whose function is not distinctly medical. While she must have an understanding of the patient's physical condition, the physical condition is only one aspect of the patient of which she must take account. As the doctor sees the diseased organ not isolated but as possibly affecting and being affected by the whole body, so the hospital social worker sees the patient not merely as one unfortunate person occupying a hospital bed but as belonging to a family or community group that is altered because of the ill health of one member. The physician and nurse seek to strengthen the general physical state of the patient so that he can combat his disease. The social worker seeks to rally to the disturbed social condition the forces of reinvigoration within him and within his environment. Thus the hospital social worker finds in the hospital an opportunity for supplementing and reinforcing medical service. Wherever hospital social workers have been able, for the sake of thorough, effective treatment, to relate their efforts most closely to those of the doctors, nurses, and hospital authorities on the one hand, and to

outside social agencies on the other, they have found their greatest usefulness. They have demonstrated that there is in medicine a place for trained workers who devote themselves to the study and understanding of social disasters, which, no less than physical disease, disturb and cripple human lives.

I have said that the spirit of service to the sick is not new. Before proceeding to those practical details of medical-social work with which this book is especially concerned, it may be well to turn back to the hospital and nursing background against which all these details must be measured and without which their relation to progressive medicine cannot well be understood.

CHAPTER III

THE HOSPITAL BACKGROUND

THE story of the Christian nursing orders, down to the organization of the Sisters of Charity under St. Vincent de Paul, is one of devotion and service to the sick which we may never hope to surpass, however much we may excel those earlier workers in scientific medical knowledge. Yet in the last quarter of the eighteenth century, John Howard, in reporting the conditions he found in the prisons and hospitals of England and France, revealed a black page in the history of medicine and nursing. His story not only disclosed the ignorance and superstition that shrouded much of the medical practice of that day but also described institutional conditions so unsanitary as to be revolting, and personal care of the sick so incompetent as to be intolerable.

The picture that he drew is in striking contrast not only with the hospital of today but also with some of the earlier types of hospitals in which the dependent as well as the sick were welcomed and treated with tenderness and skill. The reforms in medical service for which Howard pleaded and to which the Fliedners of Kaiserswerth, and later,

Florence Nightingale, made such valuable contributions, demanded just such vigorous measures as we see in the semi-militarism of the modern training schools for nurses.* Coincident with the reforms in nursing came marvelous changes in medical science. Out of all this has evolved the modern hospital, complex and technical, prepared to care for physical ills through the help of the specialized, scientifically trained physician and nurse.

Diverse factors have contributed to the increased mechanical efficiency and the growing popularity of hospitals. The administration of anæsthesia, the application of asepsis, the laboratory as a diagnostic factor, the larger use of such therapeutic measures as X-ray, hydrotherapy, Zander exercises, massage—all the modern refinements of medicine, surgery, and nursing and the team-work thereby necessitated—accent the economy of grouping many forms of medical treatment in an institution. The dangerously rapid enlargement of our cities, with the attendant overcrowding in wretched tenements, the poverty, weakened vitality, and accompanying disease, necessitates hospital treatment for an increasing number of people not well cared for at home. Another factor which contributes to an increasing attendance at hospitals is the diminishing prejudice against them. The public sees constant evidence

* See Nutting, M. Adelaide, and Dock, Lavinia L.: A History of Nursing, Vol. I, pp. 203, 205, 506, 508, 517, 524. Also Vol. II, Chapter I. New York, G. P. Putnam's Sons, 1907.

of the improved care of the sick. The attitude of the mother who leaves her child in the hospital is now less often one of despair than of hope. Patients who have been treated with kindness and skill have helped to establish in the community a justified confidence in the hospital. Such confidence has, of course, contributed to greater demands on the capacity of the hospitals. Again, the experience which medical students have in the wards frequently influences them, when they become physicians, to seek the advantage of institutional care for their private patients.

During the rapid material expansion of hospital accommodation, the attention of the institution officers and trustees has quite naturally been concentrated on the economic and quasi-military aspects of the organization and on the problems of properly housing and caring for the large numbers of patients applying for admission. But with the enlargement of the hospital and the increase in administrative work has come a division of function. The technique of administration developed in the business world has, in recent years, been more and more applied to medical institutions. Details of the management of a hospital, such as the investment of funds, purchase and distribution of supplies, employment and supervision of the large corps of employes, care of the plant, running of the laundry, providing of food, regulation of the dietary, and bookkeeping, have necessitated careful business organization. This has largely en-

gaged the attention of superintendents and trustees. They have been setting their house in order and have had little time to study its environing and supporting public. The medical work of the hospital and the relation of the hospital to the actual needs of the sick applying for care have been to a great extent passed over to the physicians and nurses.

But the staff of physicians and surgeons has been organized, not for a sensitive appreciation of what the public needs, but for efficiency and consistency of technical service and for authoritative control of the medical work within the hospital. The training schools for nurses, with their rigid organization and severe discipline, have had their attention fixed upon an earnest effort to wrest from incompetence the personal care of the sick who come within the hospital walls.

The large modern hospital with all its elaborate organization has become so like a great machine that the uninitiated often see in it an uncompromising militarism. The machinery is baldly apparent, while the reason for its existence is often obscured. This obscurity is discouraging not alone to the outsider who knows nothing of hospital life and organization, but too often to those who are part of the machinery itself. Machinery is necessary; indeed, those who really understand the problems of hospital administration realize that there is need for even better and more extensive application of business principles in our insti-

tutions than at present prevails, and that not until the machinery runs efficiently and smoothly can the hospital reach its most effective medical service. Nevertheless, smooth-working machinery cannot alone produce a successful hospital, any more than an imposing edifice, beautiful chimes, cushioned pews, and a creed can produce a church.

Because attention has been concentrated upon the internal development of the institution, the hospital has faced the danger to which all institutions are susceptible,—that of being unduly self-centered. Yet the fact that it exists in part for the sake of the community makes it, perforce, an institution the social aspect of which no technical efficiency should be allowed to obscure.

While the hospital may be unconscious of its social significance, the ultimate test of its usefulness is the flexible adjustment between its perfect machinery and the changing needs of the community from which its patients and its financial support are drawn. The rapidly growing interest within the hospital in the development of medical-social service is evidence of a desire for more thorough utilization of hospital facilities. Indefinite and variable as the conceptions of this social service are, there is still, in the desire for it, a consciousness of some social responsibility which interrupts the complacency of the self-centered, self-satisfied institution.

Not until the patient was economically boarded and lodged, not until his physical ills had been in-

telligently dealt with, could the hospital physicians see that their many failures in treatment were due in part to elements lying outside the limits of conventional medical practice. In these latter days there has arisen the candid critic of the efficiency of hospitals and dispensaries who asks whether the treatment prescribed at the hospital is carried home; whether the doctor's advice is guided by an understanding of the patient's ignorance and financial status; whether there is a sufficient search for causes of disease more remote than those found in physical examination or under the microscope,—in short, whether the hospital is merely treating the sick or is sincerely attacking their diseases by going to the root of their troubles. The beginning of such self questionings indicates a developing social conscience on the part of many who are engaged in medical service.

It is also notable that the social worker's recognition of disease as the greatest cause of human misery indicates a growing appreciation of the social significance of medical work. The common occurrence of sickness and poverty together has long been recognized as more than a coincidence. The social worker, attacking fundamental problems of modern life, has often realized that he is hopelessly handicapped without the aid of the medical fraternity. But now he is beginning to act upon this perception. Medicine and philanthropy, always in need of mutual help and under-

standing, have begun within the past decade to plan and execute their work in common.

What are the elements of the hospital community, and what are some of its inevitable conventions? Let us consider as a type a large general hospital with a visiting staff, resident physicians, laboratories, and nurses' training school.

The staff physician or surgeon who gives time and skill to the service of the hospital finds there a satisfaction in the exercise of his professional abilities. His skill is constantly being tested, his wits challenged. Each patient presents to him a more or less interesting and complicated problem. He may or may not be conscious of the human significance of his success or failure, and yet he may deal superbly with the patient's disease. Because of his unusual technical qualifications, the physician is the most important element, not only in the treating of patients but in the teaching of house officers, medical students, and nurses. Hence the hospital machinery largely revolves around him, and in the distinctly medical affairs of the hospital his position is often that of an autocrat.

The house physician, or interne, seeks a hospital service because in preparation for his professional life he is ambitious to test what he has learned in medical study and thus to obtain valuable practical experience. Under the supervision of men whose ability he respects, he acquires knowledge

that cannot be found in books. But naturally the pressure of duties upon him and his intense interest in the technical side of the work lead him to concentrate on the strictly "clinical material" before him. He usually finds a great and quite engrossing satisfaction in his growing ability to understand and combat disease, and in the increasing responsibility given him. He has little attention left for the psychical and social sides of his patients' lives.

The hospital life and atmosphere stamp themselves most definitely upon the nurse. She voluntarily subjects herself to the discipline of the training school in order to prepare herself for her chosen profession. Once admitted, she must, if she wishes to remain, subordinate herself to the regulations of the school and hospital. At a very impressionable period of her life she spends almost every hour of three years within the hospital walls. During these three years her mental processes are directed into conventional grooves. Her work is exacting and fatiguing. In most training schools of good standing, the discipline is military; there is more self-repression than self-expression; there is more emphasis on conforming to a technical régime than on the development of individual power. She is taught an intelligent use of her hands; she is also taught to observe carefully signs of physical changes in patients; and she is given a practical though superficial knowledge of the course of disease and of its treatment. In some training

schools there seems to be a tendency to forget that nursing has been established as an art. The pressure of work is so great that there is little time for the niceties of nursing practice.

In proportion to the innate imagination and sympathy possessed by the woman,—vital qualities that can be stifled but not killed,—the human interest of the nurse survives. Yet it is almost impossible to keep one's attitude toward any familiar object fresh and sensitive. Oft repeated action tends strongly to become unconscious habit. The nurse who is under the stress of great physical fatigue, under the "illusion of routine," must gradually come to take much of her work as a matter of course. While she is gaining in technical skill she is fortunate, indeed, if by the same process she is not losing some of the human sensitiveness and responsiveness which she had before coming to the hospital.

Here, then, are the visiting staff, the resident physician, and the nurses, all parts of a smooth-running machine, ready daily to care for the sick and suffering. But what of the patient? The patient's point of view is in sharp contrast to that of nearly everyone he meets. All about him he sees people apparently indifferent where he is excited, comfortably unconscious of his pain, swiftly and easily passing him through their hands as a sailor coils a rope. To this big, strange place he comes, absorbed in the consciousness of his own danger and discomfort, only to find he is one

of many, a small part of a confusing mass. He is fortunate if he can enter into his hospital experience with a knowledge of the language and with some spirit of adventure to meet the incidents of his life there. Too often, however, the hospital expects him to conform to rules and standards which he does not comprehend and to which he sometimes cannot quickly adjust himself. Fortunately, his residence and experience in the hospital leave him with a more appreciative understanding of the whole régime, and he leaves, especially if he has had the good fortune wholly to regain his health, with a sense of gratitude for what has been done for him.

Obviously the hospital is a permanent, consistent organization regulated by deep-rooted conventions. The ever shifting troops of patients form the unstable, non-resisting element,—the inchoate mass of material that must be made to fit into a more or less rigid, well-ordered routine. They come to the hospital as individuals, but the tendency is to consider them in bulk. And yet in that composite there exist marked contrasts of ability and ignorance, human frailty and weakness, superhuman courage and hopefulness in the constant presence of pain and suffering.

The hospital population may be viewed from many angles and be as variously interpreted. The mind accustomed to consider disease as a factor in social maladjustment sees in the train of all this sickness, conditions possibly causal, possibly con-

tributory, which are always more closely related to the illness of the individual than the medical specialist alone is likely to perceive. The shattered limb which means to the surgeon a demand upon his skill, may have social significance as a preventable industrial accident, attended by the tragedies of unemployment and family dependence. The nurse, seeing in the recovery of the desperately sick "typhoid" the justification for her devoted service, may have little conception of the real significance of her work in preserving unbroken the family ties,—the father restored to the support of his family or the mother to the care of her children. The pathologist may see in a smear of impoverished blood merely a routine laboratory test, yet it may be the climax in the story of a girl forced into factory life to add a pittance to the meager income of her deserted mother.

The hospital, in fact, presents material for a social as well as a medical clinic. Here it is that one sees accumulated every type of social distress, —a veritable congregation of "assorted miseries." All these complications have been recognized theoretically by many hospital authorities, but practically ignored in the urgent effort to care for physical ills. Many medical and social workers who are thoughtfully searching for the causes and treatment of human misery ask whether or not the hospital is ready for a broadening of its function; whether or not it should now look with a larger sense of its opportunity and of its responsi-

bility beyond its walls to the community which it more or less consciously serves. Well may they pause to consider the real reasons for the hospital's existence and the extent to which the patients who fill it are there through the results of their own unfortunate ignorance or through the careless indifference of society to the promotion of its own healthfulness.

Some thoughtful physicians are recognizing that in hospital and dispensary work they often do not get the results they work for and that this failure is partly due to defects in hospital methods. What conditions of hospital and dispensary work today require supplementing in order to produce effective results? An analysis of some of the characteristics of hospital diagnosis and treatment may help to show what the defects are and how they may be remedied.

Physicians on the staffs of our large dispensaries have more or less consciously accepted two different standards of medical work: one, that of private practice,—the careful consideration of the individual patient; the other, that of the overcrowded modern clinic where a hasty, incomplete consideration is all that can be given to a large majority of the sick. In a hospital, physicians usually limit the study of a patient to purely physical factors, a limitation which no conscientious physician would countenance in private practice. The hospital offers him its assistants,

its laboratories, and the instruments necessary for accurate medical diagnosis, but it has made no provision for the consideration of those other elements in human beings which the best private practitioners deem of great importance.

These elements in the complex personality of any human being Professor James has characterized as "the material me, the social me, and the spiritual me. . . . A man's me," he continues, "is the sum total of all he can call his, not only his body and psychic powers, but his clothes and his house, his wife and his children, his ancestors and his friends, his reputation and works, his lands and houses, his yacht and bank account."* Many of these aspects of the "me" play an important rôle in disease and yet may be overlooked in the rapid working of an out-patient clinic. Any deep cut or wound in the self, whether it is a disturbance of health, emotions, or finances, means a change of the whole man.

All these aspects of the patient's self the doctor in private practice attempts to understand, in order to be wise in his medical treatment and successful in his practice. He knows the temperament of his patient before he decides upon the rest cure or the work cure; he recognizes the patient's religious beliefs before he prescribes a dietary; he learns the family finances before he advises a trip to Florida.

* James, William: The Principles of Psychology, Vol. I, p. 291. New York, Henry Holt & Co., 1905.

Human beings have more points of likeness than of difference. Our instincts and our passions, our impelling desire for self preservation, our love of family and friends, our reverence for God or for an ideal, form an heritage which human beings the world over hold in common. It is profoundly modified, to be sure, by varying inherited traits, traditions, and standards of living, ranging from those of the street beggar to those of the multi-millionaire. The differences, because they are differences, stand out in our consciousness as of first importance, and tend to blind us to the likenesses. But if we are to work intelligently with human creatures, we must understand both the likenesses and the variations, and such understanding can come only with sympathetic observation and study.

It is easy to understand that in hospital patients none of these surprising identities or modifying idiosyncrasies of character and experience can be studied by the busy physician in any but a superficial way. While the care of patients in hospital wards offers more opportunity for observation of physical conditions than the dispensary clinic, there are in both services limitations of time and a constriction of the field of attention which mark the difference between the physician's private practice and his hospital service. The limitations of time as affecting the observation of the hospital patient's physical condition can be modified by better organization of medical ser-

vice. This is not, however, our present concern. The correction of the other limitation, that of the field of attention, calls for supplementary service from extra-medical fields.

CHAPTER IV

MEDICAL-SOCIAL PROBLEMS

THE TUBERCULOUS. THE CONVALESCENT. VICTIMS OF CHRONIC DISEASE

A STUDY of hospital social service throughout the country reveals a striking uniformity in the problems presented to the workers, although the organization of the departments and methods of meeting the problems are very diverse. In the general hospital, the social workers struggle with the questions involved in dealing with the tuberculous; patients needing convalescent care; the sick tenement child; homeless men, sick and unfit for work; the lone young girl facing a dishonored motherhood; the industrial problems of the physically handicapped; the feeble-minded and the insane, with their need of protection and control; the hunted slaves of drugs and alcohol; the sufferers from venereal disease and its sequelæ; the patient stricken with incurable illness needing institutional care; and the victims of black despair who have attempted suicide. The special hospitals, such as the eye and ear hospitals and those dealing with children or patients with nervous diseases, have many prob-

lems peculiar to themselves; but they are confronted also by many of the vexed questions common to the general hospitals.

Each patient thus presents not only a medical problem but a social one as well. It is because of the complexity of the social problems involved in the various groups of patients, and the interdependence of the medical and social treatment, in any attempt at adequate solution, that the social worker is needed in our hospitals. She does not despair at the diverse woes encountered, because she recognizes among social sufferers, as the physician does among the physically diseased, not only the patients who present chronic and incurable conditions, but many who suffer from acute troubles that can be cured if skilfully treated. She recognizes too that palliative measures may make the wretched lot of many a chronic sufferer more bearable, and that in a search for the causes of seemingly hopeless social diseases, secrets of prevention may be found.

It is often with a spirit of adventure that the hospital social worker faces her day's work. She can never know what tragedies, what joys, or what wonders of human nature may be revealed to her. Animated by her intimate relation to the vital experiences about her, she is eager to contribute whatever skill she may have to the service of the hospital patients.

THE TUBERCULOUS

All hospitals face the problem of tuberculosis in some form. Even though the disease may not be admitted regularly for care, it appears as a complication of other diseases. Thus in our general hospitals, as also in special institutions dealing with orthopedic and chronic diseases and with diseases of the eye and throat, we find not only lung tuberculosis but infections of bones and glands. While some elements in the medical treatment may vary with the type of tuberculosis, physicians are agreed that the effective treatment of all forms of tuberculous infection includes a hygienic régime. The program of this régime varies with physicians and with the patient's condition, but all medical-social workers must know what is meant by "rest, fresh air, and good food," and how best to secure them for the patient. For it is to the medical-social worker that the physician in the busy dispensary or hospital must look to carry out this part of the treatment.

The tuberculous patient presents a problem not merely individual but distinctly social; for tuberculosis affects the patient in all his social relations. He is often a member of a family group where infection of others is threatened. He may be living in a crowded tenement where darkness and dirt foster the life of the bacilli. He may be a workman in a dusty factory, or handling food which is sold to an unsuspecting public. It is almost futile to treat the physical symptoms of

the tuberculous patient without considering and treating his social conditions. The principles of co-operation are applied more often in the solution of the tuberculosis problem than in almost any other form of social work; for here we must have not alone the co-operation of the patient himself, but also of his family, of local boards of health, tenement-house and factory inspectors, and often of the employer and the church if we hope for any measure of success.

The hospital social worker frequently has the duty of breaking to the patient the sad news of the diagnosis, or at least of explaining to him what the doctor's diagnosis means, and of interpreting to him a plan of treatment that may promise recovery instead of the doom which seems to be foretold by such a verdict. It is at this psychological moment that the hospital social worker often has an opportunity to establish that friendly relation with the patient which is the best possible basis on which to develop a plan of treatment for the victim of tuberculosis. Physicians and social workers who have had experience with tuberculosis problems realize that what can be done for each individual patient seems to depend less on the state of the disease than on the character and temperament of the patient, his possibilities of education, and the community resources for proper treatment.

A weak-willed patient with a fretful and despondent disposition was sent to a social service department suffering with incipient tuberculosis.

After much effort his family was provided for so that he might go to a sanatorium where, the doctor said, the disease might be arrested. He stayed there two months, idle and resourceless after an active life, complaining and worrying the entire time; then left against advice and returned home, where he died a month later.

Another patient, a colored porter, emaciated but with a fire in his eye, was pronounced "advanced tuberculosis—not a hopeful case." He was too ill to be admitted into the sanatorium, for only incipient cases were accepted. He was, however, ready to make a fight. Admission being secured to a tuberculosis class, he followed explicitly all directions, slept out of doors even in the coldest weather, and accepted in a wholesome spirit the aid that was provided for his family. After a year and a half he was able to work. For five years he has now himself provided for his family. He has also demonstrated practical lessons in hygiene that have affected a whole neighborhood.

Because the plan of treatment for a tuberculosis patient depends so largely upon the home conditions and home facilities for treatment, on the temperament of the patient and on his financial status, the hospital social worker, as we have seen, becomes an important element in the development of the plan by which the patient can secure the desired "rest, fresh air, and good food," whether in a sanatorium, a day camp, a tuberculosis class, or by individual supervision at home.

To many social service departments the tuberculosis patients are sent by the physicians with tentative advice as to the form of treatment, awaiting the social worker's report of conditions at home before a definite plan of treatment is developed. But even with a knowledge of the facts, both physical and social, it is often impossible to make ideal arrangements for the patient.

Perhaps one of the most tragic situations that arises in dealing with the tuberculous patient is that of the foreigner who has come from country districts in Europe, expecting to work in our factories and to save enough to bring his family to this country. The following story is not an unusual one:

An intelligent young Greek, tall and broad shouldered, was one day sent to a social worker with a diagnosis of moderately advanced tuberculosis. His eyes betrayed his despair, but his story could be secured only through a countryman, another patient, who interpreted for him. He had been a shepherd on the hills of Greece. Upon his arrival in America he had gone to one of our mill towns hoping to earn enough so that his family might join him. His hopes, his ambitions, his young vigor became a tiny cog in the great machine of industry in an American cotton mill. In order to save all the money possible he shared a room with six other Greeks in a cheap boarding house. Discovering a night school by chance, he attended for several weeks the classes

in English, and was making rapid progress.

He became tuberculous. His eight months in the United States entitled him to no free sanatorium care. When he found that there was little chance for obtaining medical aid except as a state charge, "a pauper," and that dependence on the state meant possible deportation for so recent an immigrant, he decided of his own accord to go back to his home. With the little he had been able to save out of his earnings, supplemented by some gifts of his associates in the mill, he purchased his transportation. Knowing that the tuberculous patient is a dangerous fellow-passenger, and that the disease he was taking back to his Greek home might carry disaster with it, the social worker turned to a Greek physician, a friend of the department, who offered to instruct the patient and to direct him to a physician near his home in Greece. The social worker received a letter, some of the words written laboriously in English but much of it in his native language, which announced his safe arrival at home. The rest of the story she has never known.

So it is that our tenements and our industries are constantly sending to the countries of Europe these carriers of infection. Thoughtful social workers cannot have a part in such incidents without becoming restlessly conscious that these procedures cannot solve our tuberculosis problem; nor do they solve the problem of the immigrants who return home.

Leaders in the anti-tuberculosis movement have for several years been emphasizing the importance of segregation of tuberculous patients. It has been generally accepted that complete segregation was the ideal to strive for, for herein lay the solution of the tuberculosis question. But experience has shown not only that complete segregation is practically impossible but also that segregation in itself generates problems. The enforced idleness in our present sanatorium régime, the development of the out-of-work habit, and the abrupt change from this abnormal life to the strenuousness of community activities on discharge from the institution, all present difficulties that tax to the utmost the ingenuity and optimism of tuberculosis workers.

All of these vexed questions are having the serious consideration of physicians, tuberculosis nurses, and social workers. Suitable occupation for patients under treatment, with graduated manual labor as recovery progresses, and then careful supervision after discharge, during the period of readjustment to normal life, are now recognized as essential to thorough treatment.

With the after care of sanatorium patients the hospital social worker is especially concerned. Until sanatoria have their own social workers for after care of discharged patients it is important that hospital social workers keep in touch with those patients for whom they have arranged institutional care. Only by careful study of results

can the present expensive treatment of tuberculosis be fairly tested.

Many of the social problems involved in the struggle against tuberculosis were recognized by social workers before the medical profession was aroused to their significance. But most of the problems cannot, it is plain, be solved without the helpful working-together of those who are treating the physical disease and those who are helping to make the medical treatment possible and effective through an understanding of the social complications. The provision of material aid for the careless patient who refuses hospital care, and whose prolonged life further endangers his family and neighbors; the vexed question of withholding aid from the "unco-operative" family; the tremendous expense of supplying the kind of care which doctors feel is necessary,—all these questions are being threshed out wherever medical and social workers are making the fight against tuberculosis.

No community, city, or state has yet mastered its tuberculosis problem, although heroic efforts are being made the country over. Active anti-tuberculosis societies had been dealing with the medical-social aspects of this question before hospital social service was organized. The hospital offers merely another point for attack. The hospital social worker, spurred on by her patients' crying needs, should make herself a part of any activity directed towards the reduction of tuberculosis. Prevention, through education in laws of

hygiene, is a slow measure; but it must be taught by every social worker if she hopes to do her part. The opportunity for spreading the gospel of fresh air, food, and rest, is offered every day. Not only the patient himself, but those through whom the plan for his care must be carried out, offer further openings for the entrance of the light. The family, the friends, the church, the employers, learn that nature's aids in fighting tuberculosis are not drugs to destroy the enemy, but constructive agents to build up resistance within the body itself. The knowledge of the significance of the tuberculosis problem, its tragedies in blasted hopes and personal losses, and, most of all, its preventable nature, has aroused us, as no less cruel destroyer could have done, to our duty of providing better conditions of work and living, and better means of health-education for future generations.

THE CONVALESCENT

The need of opportunities for proper convalescence of patients discharged from hospital wards has long been in the minds of hospital authorities. But this need has been made even more vivid by the hospital social workers, who not only see patients leaving the hospital before they are fit for return to normal life, but see also the grievous results of an incomplete recovery. The expense of keeping patients in the wards until entirely well, and the continual pressure of applications for care of new patients, argue strongly for a con-

valescent ward or department connected with each hospital. Under such a plan the per capita cost of efficient medical work is greatly reduced and the régime of the convalescent's life can be better suited to his condition. The hospital social worker has been responsible for focusing a much increased demand on such convalescent homes as the community already affords, and also for developing, through boarding in the country, or home supervision, other methods of completing the recovery of the patient. There is, also, an increasing tendency to use the convalescent homes for measures of prevention, by sending many patients there who are debilitated, as well as others who are actually convalescent.

While not underestimating the value of convalescent homes, some hospital social workers have perceived that their use may have dangers. The delightfully irresponsible life of an inmate of a convalescent home is naturally appealing to people of leisurely habits. One patient who applied to a hospital social worker for care in a convalescent home was found to have paid four visits to three convalescent homes within a year. When the doctor was informed of these facts he urged light work and gradual return to self-support as more fitting than further idleness. But this prescription is obviously more difficult to fill than that of "convalescent care"; hence the temptation for social workers to use the convalescent home indiscriminately. To fulfill its greatest usefulness a

convalescent home should be used as an educational experience for the patient and his family.

A relief agent sent a seventeen-year-old shop girl to a dispensary for physical examination and convalescent care. On inquiry by the hospital social worker, it was found that the patient was going to work without her breakfast, was addicted to immoderate tea drinking, and slept with a sister who refused to have the windows open at night. A plan was made with the relief society by which the family was moved to a more wholesome neighborhood; an extra cot was secured for the patient so that she could sleep in a room by herself. Convalescent care was secured for her for two weeks, during which time she learned many lessons in hygiene which for a period of four years she has not forgotten.

Most of the patients who come to the attention of our large hospitals are city dwellers for whom a sojourn away from the dirty, crowded conditions of our great cities is most beneficial. Social workers are increasingly conscious, however, that convalescent homes are not solving the problems of "debility" for those who must soon return to unwholesome tenements and long hours of uncongenial toil. We may by occasional periods of rest be able to patch up the victims of unwholesome living; but we must not deceive ourselves by thinking that we have been striking at those deeper causes some of which are beyond the control of the individual patient.

For ward patients a period of rest in a convalescent home is often all that is needed to complete recovery. Recuperation of the debilitated body is dependent on several factors, among which are rest, nourishing food, fresh air, and a contented mind. Prejudices concerning diet and worry over financial matters can render useless a patient's stay in the most ideal convalescent home. In communities where there are no resorts for convalescents, hospital social workers have in several instances arranged to board patients in private families in the country, sometimes in the homes of trained nurses who have married or with others who are especially fitted to help debilitated patients to regain their strength. One social worker in a children's hospital has succeeded in starting a convalescent home in a farm house to which a few children at a time may be sent to complete their recovery. The experience has so far justified itself that plans are now under way to extend this "cottage plan" so that more groups of convalescing children may have the benefit of the personal attention that is possible only when they are kept in small groups. We are only beginning to see the possibilities and the problems of proper convalescence. Hospital social workers, daily facing the needs of debilitated patients, should in time contribute much to the solution of the questions involved in suitable recuperation for weakened human bodies, as well as to an understanding of the mental and physical handicap of fatigue.

VICTIMS OF CHRONIC DISEASE

Temporary or permanent care in an institution is the social prescription suggested by the physician for many of the patients whom he refers to the hospital social worker. Most communities offer some institutional care for the indigent, the insane, the feeble-minded, the tuberculous, and the chronically ill. The extent and quality of such institutions are varied, but the fact of their existence leads many social workers to make more or less indiscriminate use of them. We have often the feeling that we have taken the final step in the care of a homeless man, physically unfit for work, when we have once secured almshouse care for him. We tend to forget that almshouse doors swing easily either way, and that the officials in charge know little as to the whence or the whither of the inmates' journeyings. There is, of course, no question as to the importance of institutional care for the patient whose condition makes him a danger to the public health, or who cannot possibly secure suitable care at home. It is well, however, to be mindful of the possibility of making a better plan for care of the patient in his home rather than in an institution.

One day a man of sixty-nine years, with a weak heart and a chronic disease of the kidneys, was referred to a social service department with a note from the doctor reading, "This patient wishes to go to the State Almshouse." He was not sick enough for hospital care. The patient was a

Canadian, and a man of considerable intelligence. The story of his early life revealed the fact that he had been a ship builder. Improvidence and illness had left him without savings. For two years he had been able to do little except run a freight elevator in a building owned by a former associate. Recent attacks of dizziness had made him timid about continuing this work. With some reluctance he admitted that his wife and two sons—one of whom was "a politician who has made some money"—were living, but he did "not wish to be dependent on them." The worker, after considerable persuasion, secured his permission to confer with the family. The conference aroused one of the sons, the "politician," to care for his father rather than to let him become a state charge, and the father was persuaded that the acceptance of this plan was in keeping with his spirit of independence.

On the other hand, institutional care may be a necessary part of an effective plan for medical-social treatment. A young man, with a diagnosis of hernia and alcoholism, was sent to an almshouse hospital for surgical care. He was eager to stop drinking. Arrangements were made for him to remain at the almshouse for two months. He was then discharged in good physical condition and transferred to a special institution for inebriates, where he remained for nine months. As he was eager to make a fresh start under different environment, the patient was placed in the country at

a good job, where for a year and a half he has kept away from drink.

It is well for hospital social workers who have marked a case, "Sent to the state hospital: case closed," to find out at the end of a week or two what has happened. Such an inquiry disclosed in one case a sad sequel to the social worker's efforts in placing a patient with far-advanced tuberculosis in a hospital for chronic cases. Two weeks after the patient's admission he decided to go to Ireland, and he with his wife and four little children were soon on their way, crowded in steerage quarters and bound for a town where the care of the tuberculous is very inadequate. Continued co-operation between the state hospital and the social worker would have prevented such a result.

Patients who have been placed either for temporary or for permanent care in an institution may often be kept there contented if a human interest in their welfare can be continued through some outside person. The tragedy of a human being lost in an institution can be appreciated only by one who has experienced it, or by one who is familiar with the eager waiting of the lonely sufferer for a letter or a visitor. When there are relatives or friends, the social worker must try to make them feel the value of these little attentions to the patient. If, by any chance, the patient is alone in this country, without the ties of family or friends, then, more than ever, will the letter, the paper, the magazine—or, best of all, the

occasional visit—be appreciated. Tender care he may receive from nurses and attendants, but the disease is not the whole man; he longs for some touch with the outside world.

Volunteers can often be secured who will undertake to do these most important deeds of human kindness. For seven years one hospital social worker has kept a friendly interest in a young girl with leprosy, who was snatched away from community life to face exile in a leper colony. Every Christmas, every birthday, and many times between, papers, books, or letters are sent to this unfortunate girl, that she may feel that her existence is of some importance to at least one human being.

CHAPTER V

MEDICAL-SOCIAL PROBLEMS (CONTINUED)

THE UNMARRIED MOTHER. THE SYPHILITIC. THE MENTALLY UNBALANCED. THE NEURASTHENIC. THE SUICIDAL. THE FEEBLE-MINDED

THE UNMARRIED MOTHER

ONE of the most appealing problems in hospital social work is the pathetic plight of young, unmarried girls facing maternity. In the general hospital their numbers are often small compared to those of other groups of patients, but the utter need of the girl makes the problem loom up in all social service departments.

The problems of sex—universal social problems—are the least understood. The social, moral, physical, and psychical factors are so intertwined and deep-seated in human nature and in the organization of society that the medical-social worker must confess herself at the outset unfit adequately to cope with them. If she has a big human understanding she will recognize that the girl before her, be she shrinking and frightened, or defiant and hardened, or spiritless and unresisting, is swayed by forces both within and about her. She will also feel that the illegitimate father may be a

victim as well. She will, then, bring to the heart-rending tales that she hears a breadth of view and a sympathy which is not the sentimentality so long the common response to such tragedies. While bringing the light of intelligence and of sympathy to the problem of her patient, she can add materially if she will to the volume of evidence that may in time help to enlighten the study of causes.

Whatever theories one may evolve as to the justice or injustice of the present organization of society, one must grant that the unmarried mother of today must and does suffer piteously for breaking its laws. Any joy the experience may bring her will be the gift of nature to whose laws she has submitted. Since nature's laws are much more fundamental than society's laws, it is to the action of nature's laws that the social worker must look for constructive effort with the illegitimate mother. If we can arouse in the young mother those unselfish elements which motherhood at its best so marvelously reveals, then we may sometimes interpret to the girl the laws of society which she has broken, by showing her what obligation to fellow citizens involves.

Whether this is the proper task for the hospital social worker or whether it should be the task of some social agency outside the hospital, is still a mooted question. Social agencies have long struggled with the problem of the unmarried mother and her child. A social service department does well to study what facilities the community offers

to meet this tangled social question before installing a special worker to deal with such cases. In undertaking the oversight of the unmarried mothers, the department must face the necessity not merely of carrying them through the period of confinement, but often of keeping in close touch with them for many years. The physical pain that these mothers must endure is trifling in comparison with the mental suffering the world metes out to them, no matter how bravely they may face their responsibilities. A sympathetic and helpful friendship must last out a lifetime in order adequately to share the mother's tragedy.

There are several advantages to the worker whose task of befriending pregnant girls has its initial stages in a hospital social service department. First of all, she has the opportunity to talk with the patient at the psychological moment when she may have just heard the diagnosis or when the diagnosis which she has feared through many anxious weeks has been confirmed. The serious loneliness of the girl makes her peculiarly responsive to a friendly interest. While not much may be accomplished during that first interview, it offers an opportunity for establishing the relationship on which any future plan must rest. Another advantage which the medical-social worker may have is the detection of those patients who are not mentally normal. An early recognition of the irresponsibility of an illegitimate mother may save years of painstaking efforts toward the

building of a character that can never stand alone. Custodial care or complete protection from moral danger is the only safe plan for such a girl.

An attractive young girl of twenty was one day brought to the attention of a hospital social worker. Simply and quite unmoved, she discussed the life she had been leading and the future before her. Easily led, lacking in sensitiveness, except when her physical emotion was stirred, she had been the easy prey of unscrupulous men. A few months of observation gave evidence which was accepted as assurance of feeble-mindedness. She could not be judged by the standards nor helped by the methods which apply to the normal girl. Institutional care was secured for her to the great relief of her family, who are caring for her baby. Her ready acceptance of the institutional régime, her contentment with the simple life there, are in keeping with the irresponsibility which characterized her and which was undoubtedly at the root of her troubles.

Institutional life for the feeble-minded girl is clearly the best mode of protecting her from the temptations she is sure to meet, and society from the increase of the mentally unfit.* On the other hand, institutional care for the normal girl is unsound if it means her protection against temptations which she must encounter when she returns to community life. Especially is it unwholesome

* See Goddard, Henry H.: The Kallikak Family. New York, The Macmillan Co., 1912.

if an emotional religious experience is continually stirring in her elements closely akin to those which have brought her to disaster. Constructive effort for the unmarried mother must be based on characteristics in the girl's nature that will help her to withstand the emotional appeal of the temptations she will surely meet. We know too little of the nature of the emotional life, whether it be that of sex or religion, to be sure that the religious appeal will always call forth the religious strength to help through the hours of trial. Fortunately, some of the "rescue homes" are seeing the truth of this fact and depend more and more upon industrial training and careful following of the girls after they leave the institution, and less upon sudden conversion through an emotional, religious appeal. The hospital social worker before using such homes should know in detail what kind of work they do. They frequently offer the path of least resistance, for their doors are generously open as a refuge to the girl in despair.

Much more difficult is the process of dealing with the girl according to her individual needs. Her nature and her background must be studied to find out what there is to build upon; the helpful co-operation of her family, her church, or her friends must be obtained. She must be made to feel the responsibility of motherhood either through the personal care of her baby in some place where she can herself support her child, or by arranging to board the baby where she can see it often. The

human ties of motherhood, of family, of church, must be strengthened through a long period of understanding and friendship, so that she will be led to see what a life of service to others may mean.

The social worker must recognize that the marriage ceremony is no magic by which evil is corrected or moral character constructed. A marriage, unless it is founded on a love that will give some promise of happiness, is hard to justify. None the less, the social worker must feel the obligation that fatherhood should carry, and make an effort to bring a sense of obligation to the illegitimate father as well as to the illegitimate mother. No artificial plan for the life of the helpless little baby can modify the physical facts of motherhood or of fatherhood. If there is no marriage, it is always wisest to protect by legal procedure, whether in court or through a private lawyer, any arrangement for the support of the child and mother by the father. Most social service departments secure the services of a lawyer who is willing to help in the tangles which these problems involve.

There is conviction in the minds of many social workers that this problem of the unmarried mother is not so much the problem of the mother as it is the problem of the illegitimate child. Coming into the world without the safeguard of a home, without the protection of a father, and sometimes without that of a mother, he is sorely handicapped.

Children's aid societies everywhere are dealing with the illegitimate child with or without the mother. The Boston, Philadelphia, and the Baltimore children's aid societies, for instance, consider the illegitimate child as their charge. In recognition of this responsibility, the Boston Children's Aid Society has made an arrangement with the social service department at the Boston Dispensary by which all unmarried pregnant girls are referred to them, and they undertake the care of both the mother and the child.

The technique of co-operation in this relationship is of interest. All unmarried pregnant girls coming to the Dispensary are referred to a special worker. She secures from the doctor a statement of the physical condition and from the girl only enough information for accurate identification—such as address and names of some relatives—and for giving intelligent advice. Whatever may be secured of "the story" is passed on to the Children's Aid Society. The girl is made to feel that she is being sent to someone who will be sympathetically interested in her. She is given a card of introduction to the social worker at the Children's Aid Society and a telephone message is sent saying that she is to be expected. In especially delicate situations the worker from the Children's Aid Society meets the patient at the Dispensary.

By this plan the Dispensary makes the medical examination and supervises such medical care and treatment as its physicians deem advisable; the

social work is done by the Children's Aid Society. All contacts and transfers of mothers between the two offices are made entirely by two special workers. Monthly reports are sent to the Dispensary by the Society giving information to date of all patients referred. The following are samples of the kind of report:

*Mary Delany** has gone with her baby to her parents in Ireland, who were eager to have her and the baby come. She received $100 from her case against James Brett by settlement out of court. Mary told a confused story, which did not agree with the account of the other people in the house at the time; hence it was thought best not to have a hearing in court. The baby is in fine condition and Mary adores her.

Maud Berry is working in R. at housework. Her baby is with her sister and Maud is paying the board through us and is doing very well.

Margaret Lutz took her baby home from the hospital, a boy born Oct. 4. The maternal grandfather was arrested at about the same time and was taken from jail to the Insane Hospital after a serious attack of delirium tremens. Mrs. Lutz, who was not at all well, and extremely overwrought by these events, tried to get us to board the child. Not succeeding, and expecting the grandfather to be brought home dead any moment, Margaret answered an advertisement and placed the boy at board. Miss Croswell called next day, learned the situation, took Margaret house-hunting, and persuaded her to board the boy temporarily with the Mas-

* All names used in descriptions of cases in this book are fictitious.

sachusetts Baby Hospital while the family was moving. We made the family a loan for moving expenses and rent and within a week they left the dingy locality for a pleasant home near the Fells, where they can start over again among strangers. The grandmother will care for the baby while Margaret goes to work.

Sadie Mack. Miss Jordan, of the South Boston Associated Charities, has consented to have a friendly visitor see Sadie occasionally and try to get a stronger personal hold on her and her aunt.

Fannie Trimble. Situation unchanged.

Jane Clancy could not get into the State Infirmary because she has money to pay on her confinement expenses. St. Mary's refused to take her. The Salvation Army Home will take her but Jane says she has to think it over before deciding whether she will go there. If she does go, we shall ask the superintendent to make careful observation of her mentality.

Katie Barbarosa's baby was born at the State Infirmary and died. She ran away and the state agent endeavored to find her but all clues are lost.

Minnie Moran (née Murphy) is living with her husband in a home of their own in Roxbury. He has worked steadily earning $12 a week until two weeks ago, when he gave up his job because he thought it was too hard. Then he was sick for a week. The church helped them a little. We have given Minnie some clothes. Miss Rhodes has arranged for her confinement at the hospital. We plan to keep supervision until after the baby is born and then if Moran is keeping the home, refer them to the Associated Charities for friendly visiting.

Florence Connor went to the State Infirmary and Miss Mellon, their visitor, has agreed to supervise her. She intends to get into communication with the Maine authorities relative to the return of Florence to her own state.

Kate Alton married Mr. Dodd and is living with him in an apartment, having left her sister after quarreling with her. Miss Borden is visiting Kate. From the information we were able to get Dodd is a man of inferior character. They were married before we had time to advise against it.

Fannie O'Connor is still at St. Mary's where she was taken by her aunt without her mother's knowledge. Miss Harrison had a talk with Mr. O'Connor, who seems a sensible, honest man and is considering taking Fannie back home.

Bessie Hart was unknown at the former address that she gave on Washington St. Inquiries along Pleasant St., Abington, were unsuccessful and letters were returned unclaimed.

Annie Farwell gave birth at home to a baby boy on November 3rd. Her family will keep her at home for several months, then a married sister will care for the child while Annie works. The father of the child is not working and has shown no interest since the first. Miss Holcomb is planning to follow him up.

Jennie Cramer is still with her foster parents in Medford. Miss Wilson has arranged for her confinement at the Homeopathic Hospital and hopes that Jennie can go home with her baby. The family are planning to move to another town.

Grace Halsey was not at home when Miss Harrison

called and has not responded to letters. The young man's family had no idea where he had gone. We will keep in touch with Grace.

Mary Wilkes has been placed in a wage home under our care. Miss Forbush has been appointed guardian. The case against her brother came to nothing as Mary denied that he was implicated. We thought that Mary should properly be a state ward, but the Society for Prevention of Cruelty to Children felt that there was not sufficient evidence to warrant her commitment to the State Board of Charity, so we agreed to take charge of her.

THE SYPHILITIC

The greatest handicap in the treatment of syphilis has been the stigma that is almost invariably attached to it. The confusion in the minds of social workers that has led them to believe that syphilis is always a disgrace and never an unavoidable misfortune, has long hampered helpful cooperation between physicians and social workers in the attack on this disease. The entire lack of proper hospital facilities for the care of syphilis in whatever form is a reflection of this attitude. Many relief agencies hesitate to aid families in which there is syphilis. Children's agencies have refused to place at board children with late inherited syphilis although they present no danger to others.

Every hospital social worker is confronted with the manifestations of syphilis, whether in the young man or woman who has acquired it through ig-

norance or immorality; in the innocent young wife whose dreams of motherhood are hazarded by the curse that marriage has brought to her; in the child facing a life of blindness because of the disease imparted to it before birth; or in the chance victim whose health is jeopardized by the entrance of the vicious germ through a cut or scratch.

At the Boston Dispensary a plan of team work has developed between the social service department and the skin clinic which is of much more than local interest. The medical-social worker is a part of the clinic organization,—so much a part of it that the patients do not know "where the medical work ends and the social work begins." The following stories will tell, although very inadequately, something of the methods and point of view of the workers, and of results that are being accomplished there for the victims of syphilis:

A little baby desperately ill with congenital syphilis and past the aid of medicine, was brought by the anxious mother to the clinic, and very soon died. The mother, an apparently healthy woman, gave a history of repeated miscarriages and told the medical-social worker of her distress in not being able to have healthy children. Her husband and his family had felt that the fault was hers. The woman consented to have a blood test which was positive for syphilis. The family physician, who had known them for some time, was asked to talk with the husband to urge him to have an examination and treatment. After a diagnosis of syphilis was made on the husband, the family physician ex-

plained to him the nature of his disease, and for the first time he realized that he was responsible for the trail of miseries that he and his wife had suffered. They are both having regular treatment.

A young girl of sixteen, suffering from syphilis in a very infectious stage, came to the dispensary for treatment. She gave a false name and refused at first to answer questions. She acted as though she expected harsh judgment and certainly no sympathetic interest. The infectious nature of her disease and the necessity for treatment were explained. After a time she saw that the interest in her was real and was willing to give her confidence. The story as revealed by later social investigation was one of a wretched childhood with an unsympathetic mother, early industrial life, small pay, and the development of a friendship with a girl who had a court record and to whose bad influence she had succumbed. The patient was treated with salvarsan and soon ceased to be a danger to others. A private society helped in the plan for giving her a fresh start. She is now making a good record in a private family and being kept under medical supervision.

An intelligent young woman, a widow, came to the clinic with an accidental syphilitic infection on the lip. The medical-social worker found that she was supporting herself, her child, and her mother by candy packing. She was eager to carry out the treatment. A plan was made by which the patient stayed at home and the mother went out to work. So for several weeks this patient was kept under careful supervision until she was no longer infectious.

Another widow, a mother of several children, came

also to the clinic with an accidental syphilitic lesion on the lip. She, however, was not intelligent nor was she willing to carry out treatment. The social investigation showed that she was alcoholic and that her children were sorely neglected. In this instance the Society for the Prevention of Cruelty to Children took charge of the children. The co-operation of the Board of Health was secured on the ground that this very infectious, careless syphilitic was a menace to public health. She was sent to an almshouse hospital.

An intelligent, sensitive woman about forty years of age came to the dispensary because she had severe pains in her ankles, shins, and back. Plates for her feet were secured but gave little relief. The social worker found that this woman had been the main support of the family for eight years. She was a skilled typesetter. Her husband, crippled with paralysis, was unfit for work. Her boy of fifteen, a promising young fellow, was attending a commercial high school. The care of the husband in addition to her work proved too much for her and the medical-social worker arranged for the husband's temporary transfer to a hospital. While making arrangements for the husband, the worker secured a history of his illness which she reported to the physician. This information considered in conjunction with Mrs. D.'s persistent headaches and pains in her limbs suggested the possibility of specific origin of her difficulties. An X-ray later disclosed syphilitic disease in the bones of the leg. Treatment was immediately started (salvarsan) and she soon began to improve. This patient has never been told of the diagnosis. She was not infectious and so

not a danger to others. The husband, a hopeless cripple, was carrying the burden of his mistakes.

These records present only a few of the difficulties, both physical and social, that come to the attention of the medical-social worker with syphilitics.

Treatment of the victims not only by medicine, but by personal interest, by patient teaching, and by doing all we can to prevent the disease from spreading in the home and outside it, is essential to any adequate plan for attacking the problem of syphilis. We must also be mindful that while many of the syphilitics are not venereal infections, every infection can be traced back through other individuals to venereal origin. For this reason the problem of syphilis is a matter of physical, moral, and social concern. It can be successfully attacked only by those who see these three aspects and without prejudice seek to teach their patients to understand their condition while carrying out proper treatment.

To education also must we look for the prevention of syphilis,—not education by knowledge of the horrors of the disease, but by building decent, moral standards that will prevent the chain of infections that includes many who are helpless and innocent.

MEDICAL-SOCIAL PROBLEMS

THE MENTALLY UNBALANCED

(PSYCHONEUROLOGICAL PATIENTS)

The fields of psychiatry and neurology offer opportunities for co-operation between physicians and social workers in the busy hospital or dispensary. Among patients with mental and nervous disorders are many who are confronted with difficulties of getting along with other people which they unaided cannot overcome; also many whose presence in the community is dangerous not alone for the community but for the patients themselves.

Three groups of patients who belong to the general field of psychoneurology are now receiving the special attention of hospital social workers. These are the insane, the feeble-minded, and the psychoneurotic. After care for the insane was started in the United States at about the same time that the movement for hospital social service was initiated. This work, as we have seen, had its beginnings with the State Charities Aid Association in New York; and now through the National Association for Mental Hygiene it is receiving a new impetus. Our present interest, however, is with the opportunities of medical-social workers for service to insane patients as they come to the general hospital or dispensary.

Special workers for insane patients have been appointed at the psychopathic ward at Bellevue Hospital, New York, and at the mental clinic at the Boston Dispensary. These special workers

have two main functions. The first is to round out the doctor's treatment by securing for patients who need to be sent to hospitals for the insane the consent of relatives, and by making other necessary arrangements. The second is that of supervising those who do not need institution care. Both functions are illustrated in the following instance:

Max, a Hebrew boy of eleven years, was brought to a dispensary because he was "very nervous." The father said that the child had tried several times to jump out of the window, that he laughed and cried uncontrollably, and that he had had trouble with his teacher. During his examination the child was very incoherent,—said that his hair was on fire, that he was on "the dangerous list,"—talked in snatches about moving pictures and about his troubles with his teacher who said he "never could get well." A diagnosis of acute insanity was made. After persuading the father to sign commitment papers, the medical-social worker accompanied the patient and father to a psychopathic ward of a hospital, where the patient was placed under careful supervision. His symptoms continued to be more and more violent and at the end of a week he was transferred to a hospital for the insane. Meanwhile the medical-social worker had seen the home, the teacher, and the family physician. The teacher showed great interest in the boy. She had been troubled about his condition and had often been at a loss to know how to manage him. She said the patient had called her vile names. She had reported this to the master of the school, who made him apologize. Otherwise there had been no trouble between them. She

supposed that he was not properly controlled at home. She said also that the patient had been confused in his ideas; for instance, after a talk on hygiene in which sulpho-napthol was suggested as an antiseptic for bathing cuts, he insisted on using sulpho-napthol as a hand lotion until his hands were sore.

A home visit showed the family living in a fairly comfortable tenement although the building was dark, dirty, and in a crowded district. The parents seemed well-meaning but had not good control of the children. Nothing was found in the family history to show a tendency to mental disturbances. As the patient had been a newsboy, the head of the club was seen and the report was confirmed that Max had been acting queerly lately. He had recently come to the club and said his father set him on fire and that he was covered with blisters. He was reported as running wild on the streets, going constantly to moving picture shows, and being erratic about getting his papers. He used to forget to go for them, although he was sent with money to get them.

The little fellow was kept in the insane hospital for three months. When he was well enough to leave the hospital the doctors urged most watchful after-care. As the home conditions were unfit hygienically, and the parents were very indulgent, they were urged to pay for the child's board in the country until they moved to better quarters. Through a children's agency the child was placed in a private home under supervision, where he remained four months. Meantime the family moved farther out into the suburbs. They had learned that indulgence was not the greatest kindness to the children. When the child recovered

he returned to his home to much better conditions. There he has remained for a year reporting every two months to the doctor.

THE NEURASTHENIC

The social service department which has undertaken the most concentrated social work for psychoneurotics is that at the Massachusetts General Hospital. From October, 1907, to September, 1912, Miss Edith N. Burleigh worked in conjunction with Dr. James J. Putnam of the neurological clinic of the out-patient department, concerning herself especially with the problems of psychoneurotic women. I can add nothing to the accounts and discussions of this work as they appear in the annual reports of the department. Dr. Putnam writes:

"The physician [in a dispensary] is apt to touch the real lives of his patients as at the circumference of a large wheel; the social service worker can often penetrate more deeply and may open avenues which the physician can then follow and on which he may go still further.

"These are services which are useful in every kind of illness, but particularly useful in the case of patients with certain disorders of the nervous system. For these patients are often great sufferers from troubles which they cannot at once or easily reveal, and indeed do not clearly understand. Their fears, prejudices, and misapprehensions take on numberless forms and are often rooted in traditions and experiences which only

long and intimate contact with persons of sympathetic and thoroughly understanding minds can bring to light and counteract. Such patients need moral air and sunlight and new outlets for activity and thought as much as the tubercular patients need the physical air and sunlight through which they gain new holds on life."

In the third annual report, Miss Burleigh says:

"A psychoneurotic patient may be very like a 'normal' person except that he is a little more self-centered, more sensitive, more fearful, and more swayed by emotions. Yet the sum of these little differences may make that patient a lifelong sufferer from physical and mental pain, a burden to himself and the world. The exaggeration of certain traits and the deficiency in others are his undoing.

"What help is there for such nervous sufferers? We think much can be done to re-educate them through sympathetic interest, by reiterated explanation of the mental causes of their trouble, by encouraging them to believe in the possibility of cure and to act upon this belief. We think, too, that the social worker, acting under the constant direction of the doctor, can aid in such re-education and can supplement his efforts to find out the causes of the breakdown."

Miss Burleigh has clearly indicated the value of the social worker in outside investigation of these patients. Visits to the homes cannot be made by the doctors. Such visits do, however, contribute

much to the doctor's understanding of the patient and often help both in treatment and in diagnosis. Visits to the home and to acquaintances of the patient are valuable, not only in establishing friendly relations but also in learning the background of the patient's life,—in understanding the environment to which he so sensitively reacts. They also make possible the verification of the patient's statements.

A woman was referred from a throat and nose clinic of a dispensary to the nerve clinic because she insisted that there was a disagreeable odor in her nose which examination failed to account for. The patient said that she had repeatedly lost her work because she was so disagreeable to other people. Visits to former employers and to several acquaintances failed to find any proof of the woman's statements. No one had been able to account for her leaving her work and no one had noticed any odor about her. These facts collected through the medical-social worker furnished proof of the patient's obsession although they failed to establish complete conviction in the patient's mind. She was, however, somewhat relieved, and from time to time acknowledged that she might be mistaken. A later development of tuberculosis in this patient made it necessary for her to be sent to a sanatorium. While there she became so much interested in the other patients that her obsession about the odor seemed to be forgotten.

Patients haunted by phobias can be treated

intelligently only when it is determined by the doctor that their fears are not "real." The nervous little child who wished that the bears she saw in the corner were "real" so that they could be tied up, exemplified the suffering of these patients and suggests the necessity of providing proper treatment for them. The patients do not wish to be haunted by fears and misgivings.

Miss Burleigh tells the story of "one patient, who, broken down by the monotony of twenty years' work in one room in a mill, was full of phobias and much worried about being unable to work. Hours were spent in long talks with her in an endeavor to get at her philosophy of life. She was sensitive and eager to do the right thing, but when she gave up the work she had spent her life in doing and in which she was interested, she was at sea, unable to adjust herself to new conditions. In these talks the subject of her difficulties was threshed out and an attempt was made to show her that her future depended upon the way she took her life. She could become embittered by its apparent futility, or she could pull herself together, look persistently for the bright side, interest herself in the things and people about her, and regard her enforced idleness as an opportunity to rest and store up strength. One day she said, 'When you have thought it all out, it seems you know yourself better.' 'I shall never get so discouraged with myself again; for instance, for being thin when I want to be fat.' And again, 'Thinking about

things is no good unless you get up and do something.' Her improvement has been marked. She has made numerous unsuccessful attempts to find different and lighter work, and instead of being discouraged by her failures, is now contemplating with interest, even with eagerness, a return to her old work and old friends at the mill."

The doctor in the busy clinic cannot spend enough time with each patient to assure proper explanation and re-education. Neither can he know or treat the economic and hygienic aspects of the patient's life. What he does must be reinforced and reiterated again and again, and this can be done only by one who knows what the doctor is striving for and understands the mental conflicts of neurasthenic patients. One who is ignorant of mental processes and who is lacking in sympathy and insight and almost limitless patience may undo all the doctor is striving to accomplish.

While neurasthenia is more prevalent among women than among men there is no less need for supplementary social work in connection with dispensary treatment of neurasthenic men. Owing to the subtle elements often involved in the mental life of these patients it would seem best to leave the treatment of this group to the physicians and to male social workers when they are available. Medical students and students of divinity have in some instances served in the capacity of medical-social worker, but much has yet to be done to better this service.

THE SUICIDAL

The steps by which men and women reach the pitiable state of attempting to end their lives are the accumulative agonies of human souls. The extent to which this morbid, perverted impulse finds expression in our large cities is shocking indeed. Bellevue Hospital, New York, cares for an average of 200 attempted suicides a year. New York is only one of hundreds of cities whose hospitals are always open to save the life that seeks its own death. The hospital social worker has an unusual opportunity to search for the causes back of these efforts at self-destruction. While it may be true, as some believe, that all persons attempting suicide are, at least for the time, mentally unbalanced, there are many causal factors, social as well as psychological, that have led up to this mental bankruptcy as their logical result.

A woman, an immigrant, was one day rushed to a hospital after an unsuccessful attempt to commit suicide in a detention house at a steamship landing. The day after her admission to the hospital she made another attempt to end her life, and four days later still another. The doctors declared her insane and therefore unfit for landing in this country. The hospital social worker, who became interested in her, found that she was a Russian and finally secured an interpreter who could speak her language. The frantic patient was evidently excited over her children. Investigation revealed the following facts:

The husband had come to this country a year before and had secured work in Michigan. He had sent for his family—wife and three little children—but had not sent the amount of money required by the authorities to allow them to land. The immigration officials had detained the mother and children until the husband could be communicated with. When the money came and the officer from the steamship company went to arrange for their transfer, it was found that the children all had measles. They were hurried to a contagious hospital. The mother, not understanding this proceeding, became excited. Other people in the detention house told her that the children had been taken and would be kept in this country, and she would be killed or sent back to Russia. Confused, in a strange country, not understanding the language, unable to explain to herself why her husband had not met her, and panic-stricken at the loss of her children, this outraged mother made a frantic effort to end her life.

The hospital social worker became convinced that this woman's actions might be reasonably explained. She secured the consent of the superintendent of the hospital to retain the patient until every possible effort had been made to prove that she was not insane. The co-operation of the steamship company was secured. They telegraphed to a representative in Michigan, who sent the husband on at once. The children, now fully recovered, were brought to the hospital by a

Russian interpreter, who explained carefully to the patient that as soon as she was well she could go with the children to her husband. The children were placed temporarily by a children's agency. After the husband's arrival a conference was held with him, the doctor from the immigration bureau, the steamship official, and the hospital social worker, and the following plan was devised: The children were to be brought to see the mother regularly; the husband was to see her daily; and, if in a week's time she showed no further symptoms of insanity, she was to be allowed to land (officially!) and go to Michigan with her husband and children. This family has been for many months happily united.

THE FEEBLE-MINDED

A new approach to the problem of the feeble-minded has come with the development of hospital social service. The hospital social worker has opportunity to get in touch with these patients as they are brought to the hospital or dispensary for diagnosis, or are discovered through admission for other diseases.

Mary Acker, a woman of forty, single, was referred to a medical-social worker for immediate institutional care on account of a severe gonorrheal infection. With very little questioning, Mary poured forth the story of her experience at the almshouse hospital, where she had several years before given birth to a child. The worker had

suggested the almshouse hospital as the only place where this patient could be cared for, and she willingly consented to go. Mary also said that she had for many years been in the school for feeble-minded.

Investigation through relatives, the school for feeble-minded, and hospital records showed that Mary had had a "shock when she was three years of age and had neither walked or talked until she was eleven"; that she had always been considered below par mentally, and that she had had two illegitimate children; also that she had been for twelve years in an institution for the feeble-minded. While there, she had so far improved that her mother had taken her home. After carefully supervising Mary for three years, the mother died. For the next three years Mary had led an irresponsible and immoral life in spite of the desperate attempts of her brothers to restrain her. Their most eager co-operation was offered to secure her re-admission to the school for feeble-minded. Through the superintendent of the school and the superintendent of the almshouse hospital, arrangements were finally made for the direct transfer of the patient as soon as she was free from infection. The report reads: "Patient went happily to ———, where, after a few days, she dropped into her old place again very nicely." Three months later, the social worker visited her at the institution and found her happy in caring for some of the young children, to whom she was devoted.

Such morally irresponsible women, "high grade" feeble-minded, become a social problem, because their weakness makes them a temptation and a prey to ignorant or unscrupulous men, and through them illegitimacy and disease increase beyond our ability to measure. The harmless idiot or "low-grade" imbecile, on the other hand, may need institutional care only when it is a matter of their own humane protection. There are many of these "perpetual babies" who are most tenderly cared for at home. It is well for social workers to realize that with the overcrowded condition of most of our schools for the feeble-minded, it is often not so necessary to urge institution care for the idiot as it is for the higher grades of feeble-minded persons.

One of the distinct functions of the medical-social worker in relation to mentally defective children is to see that all possible physical defects are corrected. A physician frequently pronounces a child below par mentally and urges eye or ear examination, removal of tonsils and adenoids, or general hygienic treatment. It then becomes the task of the social worker to see that such children receive the necessary medical attention and so have an opportunity to attain normal mental development, on the bare chance that this may be dependent on remediable physical defects.

Our greatest task in relation to feeble-mindedness is to educate the community, first, in the proper protection and care of those who are unfit for self-control; and second, in the relation be-

tween mental defect and eugenics. In a comprehensive paper on The Burden of Feeble-mindedness,* Dr. Walter E. Fernald has presented the need of educating physicians in regard to this subject. He says:

"The biological, economic, and sociological bearings of feeble-mindedness have overshadowed the fact that it is fundamentally and essentially a medical question. Feeble-mindedness is a condition which is the result of certain permanent lesions of the central nervous system. This subject should receive more attention in the medical schools. At the present time, only a few schools in this country give any instruction whatever in the subject. General hospitals and dispensaries should have out-patient departments for the diagnosis and treatment of feeble-mindedness. These clinics would provide for the instruction of students. No medical student should graduate until he has a general knowledge of the causes, varieties, prognosis, and treatment of feeble-mindedness."

The skilled hospital social worker, by the accumulation of pertinent information, such as facts of heredity, school records, psychological traits and actions as seen by the family and others closely associated with the patient, can often bring to the attention of the physician data which, considered in conjunction with the mental examination, will help both in diagnosis and in making the

* Fernald, Walter E., M. D.: The Burden of Feeble-Mindedness. *Boston Medical and Surgical Journal*, June 20, 1912, Vol. CLXVI, No. 25.

best plan for treatment. She may also be able to explain to the parents, the teacher, or the social worker, the curious actions of the feeble-minded child,—his lack of concentration or consistent ambition, his love of praise but lack of persistence in effort, his inability to compete with normal children, his irresponsibility. Thus many harsh judgments may be avoided and plans developed on the basis of a better understanding. It is easy to love a feeble-minded child, but not so easy to understand his simple mental processes.

In states in which there is inadequate provision for institutional care of mental defectives, the combined efforts of the medical profession and the social workers are the most effective means for securing protection of these irresponsible people. To neglect them means a cumulative burden of illegitimacy, venereal disease, and crime for the community to bear.

CHAPTER VI

MEDICAL-SOCIAL PROBLEMS (CONCLUDED)

RELIEF. EMPLOYMENT FOR THE HANDICAPPED. MEDICAL ADVICE TO SOCIAL AGENCIES

RELIEF

PATIENTS with evident material needs are frequently brought to the attention of hospital social workers. The lack of proper clothing, the effects of insufficient food, the need of apparatus, and worry over unpaid rent present real problems, the solution of which involves some of the fundamental policies on which the social service department rests. That these special needs exist is evident; but as to the way in which they should be met there are varying opinions.

In some social service departments large relief funds are raised and freely drawn upon to furnish food, rent, clothing, apparatus, and vacations for the patients. Such departments hold that the needs are so clearly related to physical conditions as to be the responsibility of the hospital social worker, and so of the department treasury. Other hospital workers believe that it is a legitimate activity of a medical institution to provide apparatus such as braces, crutches, and glasses. Still other

hospital workers are convinced that it is not the proper function of the hospital in any of its departments to give material relief.

To my mind the chief danger of distributing material relief as a regular social service function, is the inevitable tendency to prevent a clear conception in the minds of the patients, the doctors, and the workers themselves of what hospital social service is. There is also some question of the ability of most hospital social workers to deal adequately with the tangled problems of material need. Visiting nurse associations, according to Miss Waters,* have found it unwise to allow the nurses to assume the responsibility for distribution of material relief, both because of the confusion in the minds of the patients and doctors as to the nurse's function, and because most of the nurses have not been trained for this special work. The same holds true, to a considerable extent, of hospital social workers, who are largely trained nurses, many of whom have not had special social training.

The hospital social worker should be conscious that, if the patient needs a pair of shoes, he probably needs more; and that material things should be given only as a part of a plan for the patient that will tend to make him independent of further aid. The following illustrations, taken from the records of various social service departments, may

* Waters, Yssabella: Visiting Nursing in the United States, p. 17. New York, Charities Publication Committee, 1909.

serve to indicate possible means of meeting some of the material needs that are seen in hospital cases.

A dispensary physician sent Mr. Sipe, suffering with a stomach ulcer, to a medical-social worker, because the patient said he could not carry out the doctor's prescription of "rest in bed and special diet of milk, cream, eggs, and olive oil." Rest in bed meant that he must stop work. To give up his work meant to cut off all income for his family. A relief agency was asked to help carry out the treatment that would make this man again self-supporting. Adequate relief for this patient must include not only the special diet, but provision for the family, so that he would not be tempted to deny himself and share his nourishment with his hungry wife and children. A plan was made by the relatives and the relief society by which the financial burden was fairly distributed,—the relief society furnishing the food, while relatives paid the rent and met other necessary expenses. The employer agreed to change the man's occupation when he might be able to return to work. He had been a sweeper in a stable, using a long, heavy broom, which he pushed by pressing his weight against the handle. At the end of eight weeks the man returned to the stable and was given a job as driver. For two years he has been able to keep well and at work.

Mr. Coghlan, six feet tall, broad-shouldered, and in excellent general physical condition, was one day brought to the social service department by an orthopedic physician. The doctor explained that the man had lost his right arm in an accident nine months before, and that the left arm had been so badly shattered

that, although it had now healed, it hung quite helpless by his side. The muscles were sufficiently intact to give promise of development provided the patient could have careful massage and Zander exercises daily for two or three months. The man's helplessness, despite his vigorous body, made it necessary for him to live at home, some twenty-five miles from the hospital. The wife had found work in a mill, and for several months had been helping to care for the two children, her mother, and her husband. The $300 savings were gone, and lodge benefit had been given for the year. The accident, a fall from a defective trestle at a railway terminal where he was employed as a foreman could not, according to the then existing laws, come under employer's liability. The chief need of this patient was means for transportation from his home town to the hospital. Relatives were already aiding as far as their means would allow. The employer promised Mr. Coghlan work as watchman as soon as he was able to turn in an alarm. It chanced that a private patient, whose interest had been aroused because he too had to take Zander treatment in the same room with Mr. Coghlan, was able to pay for Mr. Coghlan's transportation, and did so for two months. The lodge paid for another month. Three months' daily treatment restored Mr. Coghlan to self-support.

Mary Cole, a little girl of nine, a victim of neglected poliomyelitis, was sent to a social service department with the request that arrangements be made to secure for her a $9.00 back brace. She was the eldest of four children, and lived with her parents in a small coast town. Her father was a fisherman, and could earn

barely enough during the summer to carry his family through the winter. Other resources failing, little Mary's need was called to the attention of a summer resident, who gladly paid for the brace.

In all these instances time might have been saved if the worker had but to sign a check for the food, rent, carfares, or brace; but there are considerations more important than the saving of time in dealing with human needs. The social worker in order to know best how to administer material aid must be not merely a careful investigator of the real cause for the applicant's need of aid; she must also be constructively imaginative, and make the furnishing of the necessary relief a means not only of securing food, clothing, or money, but also of strengthening vital ties between human beings. These may be ties of family, of church, of fraternal societies, of neighborhood, of nationality, or between people whose similar experiences have established a bond.

Through a hospital social worker a boy working in a shoe shop, although alone in the world and physically handicapped, found a real friend in another boy, fifteen years old, who, having more than he needed of the material things of this world, was asked to send his partly-worn clothes to "Billy." But the friendship was not established on the basis of the transfer of coats and trousers. "The little feller," as Billy called him, recognized the greater possibilities of their relationship. The

following letter was the first of many in the development of a friendship between these two boys, although they are in different cities and have never seen one another.

"Dear William: I hear, through Miss H, that you had some clothes of mine. I am glad of it, and perhaps later I can help you some more. I don't know exactly how to write to you, because you are nineteen and I am only just barely fifteen. I am very much interested now in Magic, and I am called a Prestidigitator. I can do a good many tricks and perhaps this Christmas, if you have a boy's club, I could show you some of them. I am sending you a card trick which you can do very easily, and it is lots of fun to mystify people with it. I also send you some samples of my printing. I have a little printing press, and I printed a little weekly paper two years ago."

The problems cited are simple ones. There are many more complicated questions, such as relief of the family of a deserting or drunken father whose children show physical neglect; or the tragedy of the breadwinner who is facing a chronic disease which prohibits not only his caring for his family, but his own support. They involve the most painstaking plans and persistent oversight by those who understand that material relief should include also wise, constant friendship. Social problems such as these are too involved and long continued for a social service department to carry. This is true both because very few hospital social workers have been trained to the administration of material relief, and because the

volume of work, with its ever-increasing new problems more or less exigent, crowds out the possibility of caring properly for the needy family. We sometimes forget that the need of food that presents itself as an emergency today, demanding immediate relief, may be a constantly recurring emergency for months to come.

The giving of material relief has so long been a tangible expression of charitable interest that many people do not realize that a wise administration of material relief requires special social training. A general social training does not necessarily prepare one for the special branches in social work, any more than a general medical training prepares one to be a surgeon or an orthopedist.

The first consideration of the hospital social worker who sees the material needs of her patients complicated by family problems, should be the possible facilities which the community offers for meeting those needs. Most large cities now have social agencies skilled through long experience in relief work. In many cities the hospital workers and secretaries of relief societies are working closely together on common problems.

Many social service departments have loan funds by means of which apparatus, such as glasses, braces, and plates can be secured for patients who can pay for them in small, regular amounts. In one department a loan fund of $150 was used many times over during the year. The

most essential points to consider in regard to loans are, first, whether the patient should undertake to repay a loan or whether relief should be secured; second, that if arrangements are made for a loan they should be business-like, and the patient made to understand that he will be expected to repay according to the agreement. Unpaid loans indicate faulty work on the part of the social workers as much as irresponsibility of the patients.

EMPLOYMENT FOR THE HANDICAPPED

Doctors in dispensaries and hospitals have long been troubled by the plight of physically handicapped patients. Those with chronic heart trouble return over and over again because after discharge they have gone back to unsuitable work. Others suffering from accidents that have necessitated amputation of a limb, from industrial disease such as lead poisoning, or from other crippling disease, may have had the needed medical or surgical care, but may find self-support apparently impossible. In the first annual report of the social work at the Lakeside Hospital in Cleveland, Ohio, 1911, Dr. Warner gives the story of a mother who had come to the hospital seven successive times for treatment of a recurring valvular trouble of the heart. The 265 days' treatment cost the hospital $586. Her breakdowns were due to repeated overwork.

With the advent of the hospital social worker an opportunity for the solution of this perplexing

was suitably placed at a shop, covering boxes. A boy, crippled by infantile paralysis to the extent of badly deformed feet but slightly affected hand, was found to have an ungratified ambition to do some kind of mechanical work. Counting on this ambition to help overcome many difficulties Miss Harper made it possible for this boy to learn watchmaking. Although he was absorbed in his work, he suggested stopping for a little while during the coldest weather. His mother thought it was too hard for him to go back and forth to his work. He was persuaded, however, not to humor himself and now he is glad that he persisted. He has already surpassed the average student and will soon be prepared to support himself.

Although this department is still considered an experiment, Miss Harper, in the course of her struggles with the complexities of each patient's difficulties, has added much to the better understanding of the handicapped patient. There has been from the start an attempt to discriminate carefully between the handicapped and the incapacitated, i. e., those unfit for any remunerative work. The desire has been to concentrate on securing employment for the physically handicapped. The discrimination was to be made on the ground of physical condition.

The following instance will show that there are other elements besides physical conditions that may lead to incapacitation:

Mr. Behrens, a German of forty-six, was brought to the attention of the department because his funds were nearly exhausted and he was "in need of light work." He had an infectious disease of the joints that left him slightly lame and with hands somewhat crippled. He had not had steady work since the development of this disease some six or seven years before. Inquiry revealed the fact that this patient had been a valued employe in a Young Men's Christian Association, where he had proved himself efficient and "honorable" in the capacity of attendant at the gymnasium. Both he and his wife had been employed there for several years. In 1910 she had become insane and been placed in an institution. A lodge and a German society had aided from time to time and in 1911 had sent the patient back to Germany where they expected him to remain. In a few months, however, he became restless and returned to America. The societies again aided and attempted repeatedly to secure light work for him. When positions were found he failed to keep them.

At the time the patient was brought to the attention of the Committee on the Handicapped he was pronounced by the physicians as physically fit for work that would not necessitate heavy lifting. The patient having expressed a desire for janitor's work and also a wish to leave the city, an opportunity was secured for him in New Hampshire. After some hesitation he promised to go on a definite train and try the work. When the date arrived he came to say that he guessed he would not go to New Hampshire as he had heard of a possible job as superintendent of a club house where he might be in charge of the repairs, the cleaning, and the bowling alleys. Anyway, "maybe

he might not be able to do the work in New Hampshire."

Several other attempts were made to place this patient, but at last, at his own suggestion, he went to the almshouse. Here was a man who had at one time been ambitious and energetic, but through prolonged idleness and semi-invalidism had lost the habit of application.

Miss Harper feels that the handicapped patient almost invariably presents a mental element more or less like that of the invalid. Whether this element is due to the shock of the disease or accident, or to the family's prolonged petting of the patient, or to the out-of-work habit, is a question. It seems, however, that successful work with handicapped patients is possible only when each patient is considered individually and careful attention is given to the traits and tendencies discovered. It becomes a task, not only of finding suitable work, but also of facing a process of re-education with each patient.

George Jellife, a boy of sixteen, was referred to the Committee on the Handicapped in June, 1912, by the principal of a school for crippled children. She stated: "The boy's mother is going to live near Concord, New Hampshire, and it seems best for George to leave Boston when school closes and get employment near her." At the age of twelve George had suffered from infantile paralysis. His legs were now in irons and he used two crutches. The principal of the school reported, "he possesses application, perseverance, and willing-

ness; character not very strong; loves appreciation; is kind-hearted and frank, honest and truthful." The instructor in printing reported that George did very well for the time spent at typesetting. "He can set straight copy and would improve with practice; has not much imagination when reading handwriting if it is scribbled the way so much manuscript is. He could feed a hand press easily by leaning against the shelf in front—many people lean on the shelf, anyway. He has endurance and strength for seated work, but must have room for his legs to extend straight out when at the bench. He can also manage very well on a stool at the typesetting case."

Miss Harper talked with the boy and found him bright and eager to get a start. He was advised to wear long trousers which would conceal the irons, thus making him less conspicuous. His plan was to visit uncles in New Hampshire after school had closed, and to be in readiness to respond to a call from Miss Harper at any time. Miss Harper told him he would probably not hear for a week or ten days and in the meantime should look around and see what he could find for himself. (This was to let him realize the difficulty in securing work.) After much inquiry a letter came from a printer in New Hampshire saying, "A keen, ambitious boy is just the kind we are looking for,—one who cares for something more than six o'clock and pay day." They thought he might be useful in the label department if he could sit on a stool and feed press, or stand a little,—enough to make corrections and changes in the forms. They would first want to see and talk with the boy, however, and would be glad of more information about his condition.

George had made several applications for work, but was repeatedly unsuccessful. When word came that an opportunity was open to him, he was duly appreciative. He was personally conducted to the town, his boarding place arranged for, and the employer seen. When the time came for the worker to depart, George's courage was fast leaving and he inquired about the returning trains. He was persuaded to stick it out, however, and by heroic effort on his part and continued interest on the part of the worker he stuck to it for a month. At the end of that time he asked permission to return to the city to attend a ball game. When he appeared he was reminded of the employer's first letter stating that he wanted a boy who wanted work more than play. He went back with a new determination to remember that he was now a man and must make good. Late reports show that he is doing so.

The recognition of the importance of the mental element in patients who are physically handicapped has related this subject very closely to work as a therapeutic measure for the neurotic. Dr. Herbert J. Hall, of Marblehead, Massachusetts, has given several years' thoughtful study to the application of this principle, and to search for the kinds of work that lend themselves most suitably to treatment of nervous patients. He says:* "Manual work, used as a remedy, aims to introduce a new and objective interest, gradually forcing its adoption and increasing its prominence until

* Hall, Herbert J., M.D.: Manual Work in the Treatment of Functional Nervous Diseases. Read in the Section on Nervous and Mental Diseases of the American Medical Association, June, 1910.

the mental and physical habits of the patient are grouped about this wholesome center, rather than about the old standard of illness and complexity. It is found experimentally that this plan frequently does represent so radical a change that some at least of the troublesome nervous symptoms which may have become quite dependent on the old order drop out of sight. Manual work as a remedy, if it is appropriately and wisely used, may also, in the functional derangements, go far toward bringing about a state of self-forgetfulness, which if attained has often in itself meant a virtual cure."

Dr. Hall sees clearly that while satisfactory employment is an effectual form of treatment for patients who have become subjects for the neurologist, it also has a distinct value as a preventive measure. Hospitals that care for the chronically sick or for patients who must have prolonged rest, as in many orthopedic conditions, are sorely in need of wholesome occupation. The long hours of idleness and tedium, especially in people who have not had the opportunity to develop resources within themselves, often result in the development of a habit of mind that does not readily adjust itself to consistent employment when the patient is again able to work. This attitude has been well described as a condition of relaxation of "the moral backbone," for which the patient is not necessarily responsible. The hospital social worker sees these after-effects. To her we must look for the evidence that will make the hospitals more con-

scious of the necessity for eliminating this demoralizing by-product of medical treatment.

MEDICAL ADVICE TO SOCIAL AGENCIES

As non-medical social workers dealing with individuals in distress have become increasingly conscious of the significance of physical conditions, they have more and more sought the advice and aid of physicians and hospitals. Information as to the physical state of the patients is found to be an important element in the formulation of almost every plan for aid. The mere report of the diagnosis has little value since it is often not understood and the prognosis is usually lacking. Hence, social workers outside of hospitals who realize the importance of understanding something of physical conditions, have welcomed the hospital social worker as an interpreter.

Many hospital social service departments now feel the importance of their service as interpreters between the agencies dealing with the social aspects of the individual problem and the medical institution to which the patient has been sent for advice on the physical side. Through one social service department many children who have come to the juvenile court are sent to a dispensary for physical and mental examination before the judge decides what action shall be taken in regard to their misdemeanor. In another instance, agencies dealing with children, and those concerned especially with family problems, make a practice of

having a physical examination whenever this is indicated. In several social service departments blanks* have been printed for these cases to be "steered." These blanks are placed in the hands of the social agencies which frequently send patients for medical examination and advice. The hospital social worker is thus gradually interpreting, to the social workers outside, the kind of social facts that it is necessary for them to know.

Mr. Mann, single, forty years of age, was sent by a town authority to a dispensary through a social service department with request for a report on the man's physical condition. Mr. Mann presented a note saying that he had been a resident of ———— for many years; that he was intemperate; that he had from time to time been an inmate of the town almshouse; and that at present he was destitute. He now complained of pain in his back. The doctor in the clinic found Mr. Mann suffering from an "old Pott's Disease." The report as given by the doctor and interpreted to the town agent was somewhat as follows:

Diagnosis, Pott's disease (tuberculosis of the spine); back needs proper support. (1) *No treatment* will result in increased pain and contracted chest and the possible development of tuberculosis of lungs. (2) A plaster jacket, which would cost about $3.00, would give relief from pain but prohibit work, and probably mean almshouse care. (3) A leather jacket would cost about $15. Would relieve pain and make it possible for the patient to work, although he will probably never be well.

* See Appendix, pp. 222, 223.

The leather jacket was later ordered and paid for by the town.

The following case shows how patients sent for physical examination often need to return for treatment; also that the medical-social worker in the dispensary and the social agency outside can work together to carry out the treatment prescribed by the doctors. The patients were Mrs. Poole and her six children: Mary and Hattie, twins age ten; John, age eight; Andrew, age seven; Delia, age five; and Frank, age three.

Agency's Statement. Mrs. Poole wishes to have her eyes examined; thinks she has rheumatism. She is a widow with six children. The Associated Charities hopes to get a pension for the family, but must first have statement as to their physical condition.

Doctor's Statement. Mrs. Poole examined in the medical clinic, February 27; has a pulse of 120. The doctor makes diagnosis of endocarditis (heart disease) and constipation. Medicine is given. Mrs. Poole is to return to the clinic in a week. She is referred to the Eye Clinic, where they report defective vision. Drops ordered. To return in a week. The worker, Miss Hedley, reports the above by telephone to the Associated Charities who will see that she comes in at the proper time. Miss H. explains that the doctor is not sure as to the origin of the heart trouble, but may be aggravated by excessive tea drinking, care, work, and worry. Is told that the patient should not do washings or carry coal.

Mar. 23, Mrs. Poole brings John and Andrew to the

Children's Clinic. John is found to have obstetrical paralysis of the right arm and should have gymnastic exercises on Tuesdays and Saturdays. (This will give the unaffected muscles a chance to develop.) They will probably operate on his arm later,—transplantation of muscles. There is a suspicion of tuberculosis in Andrew and an out-of-door school is recommended. Will have the blood tested for evidence of tuberculosis (v. Pirquet test). Miss Hedley gives the above report by telephone, also sends a written summary of the physical condition of mother and children to the Associated Charities.

Three days later John comes in for gymnastic exercises and Frank for examination. No definite diagnosis is made for Frank. He should be under observation. The trouble may be auto-intoxication due to gastro-intestinal indigestion, or may be appendicitis or cyclic vomiting. Miss Hedley reports to Associated Charities and asks if they can arrange to have someone bring John in for his exercises on Tuesdays and Saturdays; also asks for a summary of family situation. A friendly visitor is secured who brings the children regularly.

Mrs. Poole comes in April 4 with Hattie, Mary, and Delia. The children are examined in the Children's Clinic. The physical examinations are negative except for carious teeth. They come in from time to time for their dental treatment. Mrs. Poole reports John and Frank are at home, both feverish and vomiting. She is examined in the Medical Clinic and found much better; her pulse has dropped from 120 to 98; she is given a tonic, and is to come to the Eye Clinic next day. Miss Hedley makes the above report to the Associated

Charities; asks to have dispensary doctor visit John and Frank, also to have home conditions made easier for Mrs. Poole.

In a few days the Associated Charities telephones that arrangements have been made so that Mrs. Poole need not bring the coal upstairs and that the housework has been made easier for her.

April 23d, Mrs. Poole's glasses are delivered to her. She now goes to the Dental Clinic where they advise having all the teeth extracted. Later, the District Secretary of the Associated Charities comes to the Dispensary to talk over the family situation. Reports that Associated Charities had been paying the family $2.50 a week but was to discontinue that until $100 which Mrs. Poole had received from her husband's employer had been used up. A plan was being considered to have Mrs. Poole go to work as stenographer and telephone operator, which work she did before her marriage. The mother and six children live with an aunt in a nice apartment near the park. They have no rent to pay nor fuel to buy. The District Secretary also asks advice as to sending John to the school for crippled children.

The next day Mrs. Poole has all her teeth removed under ether. Miss Hedley telephones this to the Associated Charities with the plan to have John and Andrew go to a vacation house for May and June under the direction of the doctor in the Children's Clinic. They are to have their teeth attended to first. The plan is agreed upon, the Associated Charities and mother each to pay $1 a week. When the children have been out in the country a week, the visiting doctor

sends John into Dispensary for operation to remove adenoids and tonsils.

During this time, Mrs. Poole complains of severe backache. She is referred from the Medical to the Gynæcological Clinic. The diagnosis is Lacerated Cervix and Perineum; rectocele (the ordinary result of childbearing and poor obstetrics). Condition found to be sufficient to account for severe pain. May advise operation later. This reported to Associated Charities.

Mrs. Poole comes in after six weeks. Reports that children were very well when they first came back from country. John is all right now, but Andrew has been coughing a good deal and spat a little blood the other day.

Andrew comes in for examination the next day and the doctor says he is undoubtedly tuberculous. The visitor will arrange to have him placed out, as it would not be possible for him to have the proper care at home. A week later the District Secretary reports that the whole family has gone on a country outing for two weeks.

Early in October, word comes from the Associated Charities that Andrew is to be in New Hampshire for the winter, where he will receive proper care. They are now giving Mrs. Poole a pension of $7.00 a week.

Mrs. Poole brings John to the Orthopedic Clinic, where massage is prescribed for two to three months in muscles of his arm.

Mrs. Poole goes to the Gynæcological Clinic. Doctor says an operation will be necessary. She is also seen in the Dental Room, where they report her gums in good condition for artificial teeth.

This story is not yet ended. It illustrates conditions in only one of the families, nearly overpowered by burdens, physical and financial, that societies for organizing charity, all over the country, are helping to their feet. Social workers in dispensaries and hospitals can often help to eliminate physical handicaps and so to aid in the constructive plans which other workers are striving to carry out for the families under their care.

Aside from the types of problems presented in these chapters there are many others continually crowding upon hospital social workers. Two very important and ever present medical-social problems in hospitals and dispensaries that have not been considered are alcoholism and venereal disease. Many physicians and hospital social workers believe that the medical approach to these social diseases offers the most hopeful opportunity for successful social treatment and for study of social causes. They also recognize that in the effort to study and to treat these diseases, physicians and social workers are essentially interdependent. Very little has so far been accomplished in this interesting but undeveloped field of medical-social service. A large amount of personal work with both these groups of patients, very special qualifications for such personal work, and more men workers who are prepared to undertake such social service, are all factors that are essential before we can hope for any measure of success.

A preliminary survey of the cases of gonorrhea attending the Boston Dispensary over a period of about six months showed that out of a group of 450 patients, 215, or 47.8 per cent, came only once for treatment and 70, or 15.6 per cent, came only twice, making a total of 63.4 per cent who came but once or twice. The ineffectiveness of such treatment is apparent, but the social bearing of this ineffective treatment and the lost opportunity for some constructive social work can only be imagined.* Out of another group of 507 men with gonorrhea attending the Boston Dispensary, 128 were under twenty years of age, and of these 75 per cent were first infections. It would be interesting and valuable to know to what extent ignorance, lack of proper recreation, or poor home conditions, lay in the background of this situation. Surely there are opportunities here for some educational work as well as for study of causes.

Another group of patients, children with vulvovaginitis, has been a matter of serious concern to both physicians and hospital social workers. It is evident that the search for the source of infection of these little girls is most important, and that the most patient, thoughtful educational work is necessary. But we are far from having determined how that educational work should be carried on. At the present time we can agree only on the im-

* Davis, Michael M., Jr.: The Efficiency of Out-Patient Work. *Journal of the American Medical Association*, Nov. 9, 1912, Vol. LIX, pp. 1689–1691.

portance of knowing the extent and possible sources of these infections.*

The great number of patients needing instruction in hygiene or in carrying out treatment form a large group for whom the hospital social worker is a teacher. A little girl of thirteen was once sent to the department by the assistant superintendent of a hospital with the word that considerable free medicine had been given to her and her sister. "Are they making good use of it?" A study of this family of eleven revealed the fact that they had all been coming to the hospital for nearly three years, especially for treatment of scabies; the hospital had granted free admission, free medicine, and free hospital care, and had spent in all $255.27.† At the time the girl was referred to a social service department, all the eleven members of the family had scabies,—a highly unsatisfactory return on an investment of $255. After one week's treatment of the whole family under supervision by a hospital social worker, the disease was cured, and for two years and a half has not returned.

In all the work that falls to the lot of the hospital social worker she must meet prejudices, ignorance, and misunderstandings. The prejudices, because of their complexities, must often be respected; in so far as they are matters of ignorance they may sometimes be overcome. So the hos-

* Smith, Richard M., M.D.: Vulvovaginitis in Children. Read at meeting of the American Medical Association, June, 1913.

† See Appendix, p. 224.

pital social worker becomes a teacher and an interpreter, and the basis of her teaching and her plans for social treatment of the patient always must be a knowledge of the social background of the patient's physical condition.

CHAPTER VII

BASIS OF TREATMENT

HOSPITAL social service depends for its justification, not on the wave of popular interest which it has recently aroused, not on the gratitude of patients for kindly help, but rather on the efficiency of the social work that is done. The gratitude of those whom we aid is not in itself a criterion of good work, although to many it has justified the indiscriminate doling of alms. Many a man in the medical profession, ignorant and ill prepared for his work, is able to inspire such loyalty and gratitude in his patients that his malpractice seems almost like a benefit bestowed.

While poor social work may not have these particular dangers, social workers must beware of similar pitfalls. Human kindness should always characterize social work, but human kindness alone cannot solve our tangled social problems; nor can it minister, unaided, to the body or the mind diseased. As I see it, the social worker's function does not lie especially in a sympathy with human nature in immediate distress of mind and body. Physician and nurse appreciate these phases of the patient's condition. Rather does

the social worker's function lie in an enlarged understanding of any psychic or social conditions which may lie at the root of the patient's distress of mind and body. Faulty character, diseased community life, and unwholesome human relations are the field of her study and constructive effort. Her knowledge of these factors, added to the doctor's knowledge of physical factors, gives a broad basis for action both medical and social. To make her contribution valuable, the medical-social worker must bring to her task the best that the profession of social work has to offer. Animated by an eager sympathy with suffering, the social worker no less than the doctor or the nurse is in search for truth. But her field is different, and the value of her contribution depends on this very fact of its being drawn from a different field.

Several factors determine the quality of the social work in a medical institution. The skill of the worker is of primary importance. Next, the kind of help that she receives from the doctors and from the hospital authorities largely decides the scope and success of her activity. Other determining factors are the number of patients in proportion to the staff of workers and the supply of helpful community resources. Last, but not least, is the willing co-operation of the patient himself. Co-operation must be more than responsiveness, but responsiveness marks the first step towards a co-operative relationship.

The patient usually has a trusting confidence in

the ability of the hospital to relieve his physical distress, else he would not seek its help. He is responsive to anyone who approaches him on the basis of his physical need. The social worker in the hospital has, then, the great advantage of an easy approach to the patient, and thus a frank discussion of his problems is made possible. Both patient and social worker tacitly recognize his physical difficulties as the final factor putting him out of joint with his environment. He appeals to the hospital for help, conscious of no responsibility for his condition. As a result, he suffers none of that loss of self-respect involved in asking material aid. When application is made to a relief society, though more fundamental causes may lie back of the obvious need, the basis on which the applicant approaches the society is that of a failure in self-support. The patient who applies to the charity hospital may also feel a sensitiveness in not being able to pay for his care. This feeling is, however, more often due to belief that he would receive better care if he paid for it. The physical need alone carries with it little of the sense of failure that accompanies economic need.

At present physical illness is looked upon as one of the inevitable experiences common to all of us. When we realize, as we may some day, that sickness is the usual attendant of ignorance, neglect, or immorality, either on the part of the individual or of the community, our point of view may change and we may cease to be so complacent about our

diseases. The time may come when tuberculosis, infant mortality, industrial accidents, diseases of occupation, many forms of blindness, and diseases resulting from fatigue will be found in our hospitals only to our shame. But for the present the patient comes as a victim, not of poverty, stupidity, or vice, but merely of the "ills that flesh is heir to." On this basis the patient meets the physician, the nurse, and the social worker, and his natural responsiveness is of incalculable aid to them. To the physician and the nurse, his relationship is largely one of dependence. The duty of the social worker is to help him to help himself whenever that is possible. His responsive obedience to the medical workers must be developed into a spirit of co-operation if the social worker is to build constructively on the foundation of the medical help the patient has received.

To establish this co-operative relation, the social worker should have all the factors in the case well in hand. She should have first of all an intelligent appreciation of the patient's physical condition, not merely the name of his malady. This is always her important first step in understanding the patient's needs as well as her basis for common action with the doctor. Next, it is her responsibility to see how far that physical condition is complicated by elements other than those which the doctor can detect by his professional methods.

In her search for these elements, which form the background of the patient's difficulties, the hos-

pital social worker must consider not only the patient's physical state as presented by the doctor, but also his mental, emotional, and social states as she can deduce them from the various sources of information open to her. Her interpretation of the patient's physical condition should include the doctor's diagnosis, and especially his prognosis and plan of treatment. The medical-social worker is usually granted the privilege of seeing the medical records, but she depends far more on the doctor's interpretation of the record as he discusses the case with her. Most medical records are so meager that one must, if possible, secure additional facts from the physician while the condition of the patient is still fresh in his mind.

This inquiry also gives the social worker an opportunity to pass on to the physician social facts that are of importance because his plan of treatment must sometimes be modified in the light of social conditions. But the social worker must keep the doctor's plan definitely in mind as the ideal formed before the hampering social complications were considered. In other words, when a compromise is necessary, the worker must remember that an ideal has been perforce abandoned, not another standard of treatment established. Take the case of a girl debilitated by working in a factory: the doctor has prescribed rest, variety of food, and outdoor life; but she may be compelled to receive a plan of treatment involving, instead, a better understanding of the laws of hygiene, or a

change of occupation, because any attempt to give her a radical change of environment could only be temporary. Thus, the social worker must at times be willing to accept a second best plan for her patient, but she must not lose sight of the fact that it is second best when considered from the physical side alone.

The psychological elements, which the social worker must consider, are of fundamental importance. They include the patient's character, his temperament, his reaction to the experience of illness, and his attitude toward those endeavoring to help him. To those who know people in physical distress it is a commonplace that the psychological may in so far color the physical condition as to make the same disease in two individuals seem due to different infections. This is equally true in economic conditions. Poverty may take the vitality out of one man, may find another philosophically acquiescent, and spur still another to renewed efforts. Prosperity produces a similar variety of results.

In the interplay of the physical, economic, and psychological factors, the psychological dominates; hence the understanding of this subtle reaction of human nature to circumstance should engage the most thoughtful efforts of the medical-social worker. To secure a knowledge of the patient's character involves piecing together facts from many sources: from his looks, manners, dress and bearing; from what he says; from the atti-

tude of his mind towards the difficulties of his life; from all that can be learned about the time of "his high water mark" in the social world; and from his own hope or despair as to the future. A knowledge of these factors is often of much more importance to the plan for the patient's future than the knowledge of his previous economic condition. The worker's understanding of these aspects of character depends on her power to see meaning in the facts which she collects by the conventional methods of history taking.

The first talk with the patient may disclose very few social facts. It may be that the only essential element in the first interview is to secure the patient's confidence, to establish a friendly relationship, and to explain to him her own function as related to that of the doctor and nurse. In our work with nervous patients or girls in moral danger, this is particularly true. In their eagerness to get at social facts, social workers sometimes expect to enjoy the confidence of the patient before it has been gained. Usually, however, the medical-social worker has little difficulty in taking this first step. The plans of an outside social worker must sometimes be explained to the patient; but the patient readily understands the hospital social worker's function, because his need of her is always closely related to his immediate physical difficulty.

There is a skeleton of information about the patient which it is necessary to secure if we are to

have even a superficial knowledge of him: his age, his residence, his nationality, his part in the family group, his occupation, something of his economic situation. These facts can be ascertained through direct questions; they give a background for further details and sometimes offer clues to the causes of his difficulties. I recall a patient sent to a social service department in order to ascertain the possible source of his lead poisoning. The man gave his occupation as shoemaking. The social worker noticed a peculiar habitual movement of his mouth. Following this clue, she discovered that for several years he had held in his mouth while at work the little pegs used in his trade and thus absorbed the metal into his system.

After securing the first necessary facts it is well for the social worker to ask as few leading questions as possible; rather she should have the patient tell his story as fully as his time and her own allows, guiding him sometimes and selecting from his disclosures those facts which bear particularly on the social aspect of the case. The art of a first interview involves questioning and listening with a plan in mind, but with a perpetual readiness to change that plan. Direct questions tend to bring out only the facts which the worker is looking for and may leave hidden some of those unexpected sources of anxiety and difficulty that are the real source of the patient's trouble.

A woman sent by the doctor to a hospital social worker to secure her medicine free, was found on

investigation to be struggling under a burden too heavy for her to bear. Since she and her three children had been deserted three years before she had supported them by day work. A son was found to be desperately ill with appendicitis at the city hospital. Another child, concerning whom the mother was greatly worried, was found to have incipient tuberculosis. Had the hospital generously donated the tonic which the doctor ordered for this mother, and given no consideration to her anxieties for her children, the tonic would have profited her little.

If a patient's social problem is uncomplicated, a superficial knowledge of the facts may be all that is needed. It is impossible, however, to tell beforehand how far an investigation must go. When Lincoln Steffens began to investigate the shame of the cities, he soon found that he must follow the trail to the state capital and ultimately to Washington itself. With the doctor's diagnosis and plan of medical treatment at hand, one must realize that the aim of the social investigation has not been attained until an effective plan of medical-social treatment can be formulated to meet the needs of the patient. On the other hand, it takes as much discrimination to know when to stop an investigation as when to go on with it. The only sure way to test any decision based on such superficial knowledge is to follow up the case and see whether the result has been what the worker anticipated. If a patient has flatfoot, but is otherwise in good

health and able by an easily arranged plan to pay for her plates, no further activity on the part of the social worker may be necessary. On the other hand, a little further understanding of the patient may indicate the necessity for her changing her work to one less trying to the feet. From the comparatively fortunate state of this patient, there are all gradations to the desperate condition of the sufferer for whom at present nothing can be done either medically or socially because with our present limitations no amount of social knowledge, investigation, or work can make treatment effective. Thus, most social workers feel a hopelessness about confirmed alcoholics and drug habitués.

Investigation of the social side of the patient's life is tabooed by many who do not understand its motives or values. Often the doctors themselves are impatient of social investigation. There are those who, blind to its real significance, regard the questioning of the patient as an impertinence. But impertinence implies a base motive. If either the doctor or the hospital social worker has a plan in view into which the answers to the questions fit as a piece into a puzzle picture, and the plan is for the good of the patient, there is no possibility of impertinence. The social worker must be ready to explain to herself or the patient the reason for each question she asks. There can then be no misunderstanding on either side. During the questioning, facts of character come

out on both sides, facts which help in later relationships. The hospital social worker who has learned something of the art of dealing with people will never allow her questionings to become stereotyped. The information which she seeks in each case will bear close relationship to the need which seems at the time to be urgent.

A visit to the patient's home is often essential to a better understanding of the social status and living conditions of the patient. It also serves to illuminate the patient's trouble from the family's point of view, which is sometimes much saner and usually somewhat different from that of the patient. To carry out an effectual plan usually requires the family's help, and at times a plan is greatly modified in the light of a home visit. The following case illustrates the value of learning the home conditions:

A nervous little girl of fifteen was once referred by a neurologist to a social service department with the request that she be sent to a class for stammerers. A teacher of articulation had told the neurologist that he would gladly take some patients in his Saturday afternoon class. Realizing the social and economic handicap of her affliction, she stammered out her appreciation of this opportunity, which was all the better because it would not interfere with her working time. A talk with the patient and a visit to the home revealed the fact that this anæmic, nervous girl was working nine hours a day in a net and twine factory, where her fingers were flying every moment; that daily she walked

a mile to her work and a mile back; and that at the end of the day she returned to cold rooms and to entirely inadequate food, improperly prepared. The mother, a prematurely old widow with two daughters, worked all day in a factory,—though she was entirely unfit for it,—and had no strength after her work to attend to the physical needs of her family. The total income of the family was eight dollars a week. Through the efforts of the social service department, the church and a relief agency were called upon to supplement the income and the patient was sent away for several months' rest. After a year of watchful oversight the social worker succeeded in bringing the patient to the condition where she was fit to have the training in speech.

The patient's family is usually more ready to co-operate when the trouble is physical than when it is economic. The thought of pain and possible death rouses a sympathy which is keener and quicker in its action than that produced by the thought of poverty and unemployment. The worker should make the most of this psychological situation both for securing the information necessary to perfect her plan and for interesting the family in the success of the plan.

If the patient has a suggestion of his own, that should be first considered even if it is an impossible one, for he is more likely to give his co-operation to a modification of his own idea than to a perfectly new one. In fact, the final plan must be a composite adjustment of three points of view,—

those of the doctor, the social worker, and the patient.

Patience and tactful persistence are often necessary to bring about the adjustment of these three points of view. A young man came to a dispensary for treatment of enlarged glands in his neck. On examination it was found that these glands were tuberculous and that there was an incipient tuberculosis of the lungs. Immediate sanatorium care was advised by the physician, and the medical-social worker was asked to make the necessary arrangements for his admission. The patient and his family had a fear of hospitals which the worker could not overcome. Failing this, she kept watch of the patient at home, instructing him in hygiene and urging him from time to time to accept sanatorium care. After a few weeks an abscess developed in the glands of his neck. The patient then consented to enter a general hospital for a few days to have the abscess treated. This experience dispelled his fear of institutions, and he consented to go to the tuberculosis sanatorium immediately after his discharge from the general hospital. Thus the original plan, although belated, was carried out, with the most sincere gratitude of the patient and an appreciation of his former misjudgment.

In many cases the interview with the patient at the hospital and one home visit suffice to secure the needed information. Success is marked by our ability to formulate an effective plan of treatment

without further study. By the time the investigation has gone as far as this the worker should at least begin to see which personal tie the patient regards most tenderly and which influence can be strengthened to help solve his present difficulty. These aids may be found in the family, the church, the employer, the secret society, or a friend,—in fact, in any of the natural ties. These factors in the individual's life are not only many times essential to effective treatment, but through them information may be secured for the foundation of the plan of social treatment.

The sources of information about any patient then are varied and can be completely utilized only by the social worker who knows how to follow clues and to discriminate between those that are important and those that are unimportant. Many a bulky social record has missed the essential points.

A tentative social treatment based only on superficial study is sometimes necessary in view of the urgency of the patient's condition. In medical work the patient with a hemorrhage is treated immediately to stop the bleeding before further examination is attempted. It is recognized, however, that hemorrhage is a symptom and not a diagnosis. Back of the hemorrhage may be tuberculosis of the lungs, or an internal injury that must be treated before the patient can possibly recover. Just so the emergency outfit of clothing that may have to be supplied to the patient is

only the treatment of a symptom. Patients who need material aid almost invariably need more than that, and the hospital social worker should not be content with emergency social service, except in the very rare cases when emergency service is really all that is needed. A sick person in need of material things is peculiarly appealing. A grocery order, like a dose of morphine, may ease the present situation. But the medical-social worker must remember that such relief can rarely prevent a recurrence of the need. The cause of the need should be the object of her search, for not until the cause is known can any constructive plan be developed.

Social investigation, like medical examination, may be either simple or involved, local or systemic. The surgeon who is called upon to treat a broken arm does not first take the patient's family history before setting the bone. If there are no further indications of difficulties, the bone is set and the patient departs. If the patient presents obscure symptoms which necessitate more extended examination, the diagnosis may have to be deferred until by the X-rays, by laboratory tests, or by a period of observation the true condition is revealed. While minor symptoms may be treated from the first, an intelligent plan must be delayed until the physician has determined the diagnosis. In the same way the skilled social worker must be able to distinguish between these two degrees of involvement of the patient in social difficulties,

before she can know how extensive to make the examination or what plan of treatment to follow.

I remember a patient sent to a social service department by the admitting physician of the dispensary. He had admitted the patient later than the hospital rules prescribe, after she had told him that she had walked from her home. He asked the social workers to arrange for her fares to and from the hospital during the time she needed treatment for some local disease. The social worker had a talk with the patient and visited the home, where a friend also was seen. Here she discovered that the family was in no financial need, as the husband was earning $18 a week and provided well for his wife and children. The woman stated that she had been "very nervous for several years," a story which her friend corroborated. The patient was eager to talk of her symptoms and troubles, and finally it came out that she had a fixed idea against riding in street cars and had not been in one for several years,—not even on the day after the superintendent so kindly gave her her carfare. Thus was disclosed a mental condition far more serious than her local trouble, and more difficult to cure. To give her carfare was aiming wide of the mark.

We must not give the doctor or patient any surmises or guesses which can by any possibility be construed as facts. Facts can be secured only by an intelligent search, by balancing sources of information, and by a critical attitude toward prejudiced statements. Many things tend to blind us

in our search for the facts in social investigation. First, the lack of experience on which to base sound judgment. Second, our own emotional response. We are inclined to inject our own feeling into a judgment of the patient's distress of mind, and to formulate an opinion without getting a true perception of his condition. But the sick patient's point of view is often warped, as also may be the point of view of his family. That is one reason why he needs the social worker as an adviser. If she is to do her greatest service she must keep her judgment balanced and sane.

One young boy of sixteen was more in need of the social worker than he realized. His legs had become quite helpless through an attack of poliomyelitis that had not been skilfully treated. The best the doctors could do for him, when he came to the attention of a well-known dispensary, was to prescribe braces, so that he could walk with crutches. Two or three years of sickness and idleness, and an indulgent family, had left him with little ambition. The social worker had not only to teach this boy patiently and persistently to keep at the job she secured for him, but also to strengthen the morale of his family so as to prevent them from giving him entire support. She taught both the patient and the family that happiness was to be found in work, not in idleness, and that the best protection for this boy was an ability to care for himself.

Failure to take into account all the important

psychological elements involved in such a situation as this would make social treatment ineffective. Thus, only after seeking for the many-sided truth, whether it is a matter of finances, hygiene, psychology, or past experience, can a sound plan of action be developed. Often the truth when found reveals little promise for effective effort. Many a social worker has spent months or years of fruitless struggle at reconstruction of character, only to find that the boy or girl was feeble of mind and consequently incapable of self-control. If the facts had been known earlier much energy, unjust criticism, and disappointment might have been saved.

In discussing the aim of the medical-social worker's investigation, Dr. Cabot once said to me, "Patient and worker can rest content when—and only when—they have done *either* what is efficient *or* what proves that efficiency is here and now impossible. Miserable uncertainty and fruitless effort are the worst of the miseries to harassed social worker and to struggling patient. Next to being cured there is a very genuine satisfaction in knowing that one must endure,—to place one's fate and find a foothold *somewhere*, even in defeat. Definiteness—after exhaustive study—is the one thing all patients can rightly demand and all workers rest upon. It is no mean support. I have seen its benefit to many. It sets worker and patient free to think clearly about something or someone else."

CHAPTER VIII

WORKING TOGETHER

THE number of charities or social agencies in a community is not a true measure of its strength for social good. The organization of each relief society, each welfare association, and the building of each charitable institution or social settlement is a tangible expression of philanthropic or civic interest; but their existence does not guarantee their efficiency or the community's need of them. In certain cities there are charitable agencies initiated through the efforts of small groups of people who, knowing of individuals in distress and interpreting that distress as evidence of a community need, have sought to meet it by organized effort. Other agencies are maintained by legacies left by philanthropically inclined but socially ignorant persons. In this way there develops a crop of more or less heterogeneous, unrelated charities. A city may be oversupplied with orphan asylums, "rescue homes," or day nurseries, while at the same time crying needs, such as playgrounds and amusement centers, remain unmet.

In some cities the uncontrolled multiplication of

agencies for relief has resulted in much duplication of function. While it is reasonable to assume that no expression of human interest is wholly wasted, we must grant that much strength is lost if there are no unity of aim and no harmony among the charitable forces in a community. The hospital social worker, while having special functions of her own, needs much assistance from various social agencies. She cannot build up within the hospital a well organized associated charities, a relief society, a factory inspection department, or a department of school nursing. All large cities are supporting such agencies as these. She can do her part toward creating a sense of relatedness among the agencies that she uses. For instance, she may see fit to introduce the truant officer to the clergyman in an attempt to relieve the anxiety of a father who is having difficulty in keeping his boy in school while the mother is in the hospital. In her struggle with vexing questions the hospital social worker must work shoulder to shoulder with other social workers.* Through this experience she comes to feel that spirit of social service which humbly recognizes the smallness of individual effort in relation to the greatness of human need and is inspired by the high enthusiasm that arises when many work together for social righteousness. The real measure of the community's strength for

* See Byington, Margaret F.: What Social Workers should Know about Their Own Community. Published by the Charity Organization Department of the Russell Sage Foundation.

good, then, lies not in the number and variety of its institutions, not alone in the personality or enthusiasm of its social workers, but also in the effective joining of their forces. The effectiveness of such co-operative effort is the principle recognized in campaigns for better housing, anti-tuberculosis crusades, and all the social-educational programs.

Hospital social service aims to bring to the patient's aid the particular community resources which will most effectively assure his return to health. Hence the social worker must know what these resources are and how to use them judiciously. She can no more afford to be ignorant of these resources than a doctor can afford to be ignorant of the remedies used in the treatment of disease. They are her social pharmacopœia. Nor must she be too dependent upon any one social remedy as a cure-all; there are quacks in the treatment of social disease as there are in medicine. The diet order and convalescent home offer examples of the remedies often given but not always adequate to the need. The real test of the social worker's skill is her ability to diagnose accurately the social conditions of the patient, to prescribe intelligently, and to find the means to carry out effectively the treatment best suited to a particular social condition. The tired girl may need not only a week in the convalescent home; she may need to be taught how to sleep and to eat, to get proper amusement, or to bear a burden of sorrow.

Sometimes the social worker in prescribing social treatment must depend on changing the environment. Sometimes the remedy must be compounded out of the forces within the individual so as to help the patient to help himself; thus it is with the neurasthenic patient. Still another patient may need the aid of several agencies in the community that exist to alleviate his special forms of distress. The social worker must then construct a plan that skilfully combines these forces. She must have the kind of skill shown by the physician whose carefully balanced prescription combines several drugs in such proportions as to be much more helpful than any single remedy.

The hospital social worker has a special opportunity to understand and encourage co-operation. She hopes to see the hospital become a more consciously social institution than it is at present, but neither she nor any enthusiastic promoter of hospital social service wishes to have the hospital lose its characteristic function as a technical institution for the physical care of the sick. The hospital cannot and should not so enlarge its functions as to be able to meet all the needs of those whose physical well-being it seeks to promote. Recognizing this, we should not attempt to multiply the special activities within the hospital itself, but should turn to the community to discover and use the many agencies already developed to deal with social wrongs and misfortunes.

The conviction in the minds of many, that the social problems of hospital patients are unique, is soon dispelled by a real understanding of the functions and activities of the other agencies. Many of the problems that come to the medical-social worker are human tangles involving numerous other elements besides poverty. Fatigue, moral dangers, alcoholism, and incurable disease are some of the evils that attack mankind irrespective of economic condition. Because they are often further complicated by poverty they are familiar to charity organization and relief societies. The great majority of patients with medical-social needs, especially those whose needs are most dire, belong to the same group of people who come to the attention of other social agencies. While the hospital population represents a great variety of economic levels, it would seem that the large bulk of people frequenting our charitable hospitals are near the poverty line, many of them victims of the social distress with which charity organization societies, visiting nurses, settlements, and relief societies have long struggled.

No thorough survey of the industrial, social, and financial standing of hospital patients has ever been made. There are in our hospitals, no doubt, some whose disease is the result of wretched social conditions; others whose disease may prove to be the road by which they will enter the field of wretchedness and dependence; and others still

who by a narrow margin will again become self-supporting when they recover.

A step towards an enlightening analysis of the patients coming to a charitable dispensary was taken in the winter of 1911–12 at the Boston Dispensary. The study covered only 116 patients,—the total number of "new" patients applying at the hospital on two days. It is, however, valuable, first because it proves that hospitals have the opportunity for social service to people on a variety of economic levels, and also because it exemplifies a method for determining roughly the financial standing of those who apply for free dispensary treatment. Among 116 patients the investigators found the following economic conditions, classified according to the groups defined in Booth's "Life and Labor of the People of London."

"Casual Laborers	8	
Unskilled labor, low paid, irregular work	21	
Unskilled labor, low paid, regular work	36	
Total of unskilled and casual labor		65
Skilled labor, irregular work	13	
Skilled labor, regular work	19	
Total of skilled labor		32
Clerical work	9	
Business (managers or owners)	6	
Professional occupation	1	
Total of clerical and higher grades		16
Total		113
Patients living in an institution		2
Information insufficient for grading		1
Grand total		116

"Thus, 56 per cent of the patients are in the grades of unskilled labor or below; 28 per cent in the class of skilled labor; and 14 per cent are in the clerical or business groups.

"It would be an error to draw from these percentages any direct inference as to the proportion of patients who could have paid a private physician. Eligibility for dispensary treatment cannot safely be determined from economic grade alone. The members of the family of a clerk earning $18 a week, with six children, may be much more suitable subjects for 'medical charity' than an unmarried laborer earning $12."*

It will be seen that to meet the needs of these various groups of people various social forces are required. For that reason the hospital social worker must be resourceful and imaginative, ready to grasp her opportunity to adapt social service to many people with many kinds of needs.

A catalogue of the city's resources is an invaluable help in effective co-operation. Many cities have charity directories in which the various agencies are grouped according to their function, with indexes, cross references, and annotations to suggest the means of approach, such as the names of the executive officer and the office hours. The city directory with its wealth of information concerning churches, lodges, and business organizations, and the yearbooks of the various churches

* Davis, Michael M., Jr.; Efficiency Tests of Out-patient Work. *Boston Medical and Surgical Journal*, Vol. CLXVI, No. 25, p. 917.

are also most helpful. Of the smaller towns and cities few have any published catalogue of their charitable resources, and the worker is dependent largely on the accumulation of her experience for a knowledge of the agencies in the community that are available for her.

With the frequent shifting of workers, some way of preserving the accumulation of experience is very important. A simple method of accumulating valuable information about the community's resources is to make a card catalogue of such resources as do not appear in any published directory. Such information can be carefully classified according to subject and location so that it may be readily accessible for future use. A catalogue of this character should contain the names of lodges and benefit societies, their officers and addresses; people interested in special nationalities,—for instance, Poles, Italians, Swedes; special information on church clubs, charities, and funds. The names of firms and notes of prices for outfits for tubercular patients—tents, chairs, sputum cups, paper napkins—should be secured; the names of carpenters who will build outdoor sleeping porches; reliable boarding places with notes about accommodations and prices; the names of lawyers, doctors, and interpreters who will volunteer their services, or of individuals who would give time and personal interest to patients needing friendly oversight and long continued supervision. Such a catalogue is especially valuable to

those social workers whose field covers not only the city in which the hospital is located, but extends over into the suburbs.

In the social service department at the Massachusetts General Hospital some 500 "resources of suburban towns" have been accumulated and tabulated in card catalogue form during seven years. The case number of a patient helped by any one of these persons or agencies is often entered on the card, so that reference to the case record will give more details about the quality of help secured. It has been found necessary to assign to one person the task of keeping this catalogue up to date.

One very helpful feature of such a catalogue is in presenting conveniently information about other hospitals. Much effort is saved when, by consulting the card catalogue, one can find out the hospital resources of the city, both private and public, the types of cases accepted, the scale of charges, and the quickest way to get patients in. Cross reference cards indexing the special groups of cases accepted, as cancer, chronic diseases, and tuberculosis, are also useful.

Both public and private agencies are to be found in most cities. The public agencies represent the responsibilities which the community has already accepted. The obligations first recognized by the state are those for protection of its citizens through prisons, insane asylums, almshouses, etc. A gradually enlarging sense of civic responsibility

constantly increases the number and variety of public agencies. Most cities have a charitable and correctional group of public institutions which deal with the economically dependent and with those whose conditions, moral or physical, are a menace to the community. Among the city and state agencies most used by the hospital social worker are hospitals, almshouses, institutions for the care of the insane, epileptic, and feeble-minded, sanatoria for the tuberculous, overseers of the poor, boards of health, tenement house and factory inspectors, school teachers, physicians, nurses, city ambulances, and still other agencies concerned with the sick in their homes.

Private agencies usually originate with a small group of persons who hope to demonstrate whether or not the value of their activity is sufficient to deserve its permanence as a public benefit and a public charge. Examples of such effort are seen in the services of school nurses, anti-tuberculosis societies, and milk stations. Established by private initiative, they have in many large cities been taken up as legitimate activities of the city government.

Among the private agencies with which the hospital social worker should be familiar are those for material relief; those dealing with needy families—such as the associated charities (or charity organization society) and Jewish relief societies; the children's agencies, both those that place children in foster homes and those that supervise the

child in his own home; the societies for protection of children from cruelty; the visiting nurses, school nurses, teachers, settlements, churches, lodges, and benefit societies; and the many religious organizations, such as the Society of St. Vincent de Paul and the King's Daughters.

Every community has some if not all of these agencies. To know where they are and how to work with them is one of the hospital social worker's first qualifications. In a large city it is very difficult to bring all the complex social agencies into friendly team work. The best way to cut out duplication of effort, and to achieve quick, efficient service to the needy is found in the "confidential exchange" of information, or "charity clearing house."* Such a bureau has been established in several cities. The oldest exchange is that maintained by the Associated Charities in Boston. Eighty-seven social agencies use this exchange. Its machinery is simple and effective. The names and addresses of all persons inquired about are arranged in a card catalogue, with a note stating what agency or individual is interested in that particular person or family. Thus this exchange serves not as a bureau of detailed information concerning any individual but rather as an index to persons who are under the care of one or another of the social agencies in the city. When inquiry is made by telephone or mail

* See Byington, Margaret F.: The Confidential Exchange, a form of Social Co-operation. Published by the Charity Organization Department of the Russell Sage Foundation.

the file is consulted. If the name of the person inquired for is already known to any agency, the person inquiring is told *that fact alone.* Any information concerning the person must be secured through the agency or individual already interested. The confidential exchange itself gives out no information other than this. If there has been no previous inquiry, the identifying information and the name of the agency or individual inquiring are filed in the catalogue. The card is not consulted unless someone else becomes charitably interested.

The success of such a bureau depends upon three conditions: the intelligent, business-like management of the bureau by those in charge; the strictest sense of the confidential nature of all information; and the intelligent and prompt use of the information secured by the inquirer. Despite careful management a bureau may be rendered useless if persons inquiring do not follow the clues given them through the exchange, and so fail to get into touch with other persons who may at that very time be actively interested in the same patient.

The following illustration shows the value of the confidential exchange:

A patient was asked to come to the out-patient department for the dressing of an acute abscess. The surgeon reported to the social service department that she could not come because of her baby. She was a Hebrew and spoke almost no English. The social worker immediately telephoned to the confidential

exchange and found that the family had been known to several social agencies for many years. The state had charge of two children, a children's agency had charge of an infant but was about to return it, and a Hebrew society had for some time known the family. It was the baby's return that was worrying the mother. The father was anxious to care for his family, but ignorance of the English language and lack of work had forced him to seek assistance. A conference of those actually interested in the family was called. The hospital social worker reported the physical needs of the woman. The children's agency decided to keep the child until the mother was fit to care for it. The Hebrew society renewed their relations with the family and secured work for the man, while the medical-social worker kept supervision of the patient until she was well.

This solution of a complicated family situation took very little of the hospital social worker's time and was satisfactory to all concerned. A second case illustrates the waste of effort due to absence of registration.

The parents of a very troublesome feeble-minded child were loath to send him to an institution. After much effort on the part of the hospital social worker they were persuaded to apply for the child's admission to a school for the feeble-minded. When the application went in, the social service department was informed by the institution that another application had been previously filed by a children's agency. On consulting this agency it was found that it had gone

through the same struggle to persuade the parents of the wisdom of custodial care. The parents had come to the hospital in the hope that an operation could be performed which would cure the child and make institution care unnecessary.

A contrast is shown in the following illustration:

A woman came to the hospital in urgent need of immediate operation. She refused to enter the hospital because she did not know what would become of her children. On inquiry at the exchange it was discovered that the family was known to the Associated Charities. The hospital worker telephoned the friendly visitor who had known the family for a long time. She eagerly shouldered the responsibility for the care of the children, and made a plan for the husband during the wife's absence. Thus relieved of her anxiety, the woman entered the hospital. The hospital social worker kept the friendly visitor informed of the woman's condition. The visitor persuaded her to continue her convalescence until she was in fit condition to resume her family cares.

To those who have used the confidential exchange for many years it becomes an expression of true co-operation. It not only says, "Let us know if anyone is already interested in this patient," but it also says, "I am interested in this patient and stand ready to help." Through the operation of the exchange, social workers in the community are continually reminded of one another's existence. Where no such exchange exists, a conscious effort is often necessary to keep one-

self mindful of the fact that there are other social workers struggling against like problems. Exchange of experience is not only enlightening but may be highly stimulating.

Honest differences of opinion or of methods among social workers sometimes lead to critical judgments and misunderstandings on both sides which may be destructive of valuable co-operative effort. If, however, social workers have faith in one another's motives, differences of opinion and method may be wholesome elements in their relations. The fine feeling of friendly criticism that has existed in many cities between medical workers and social workers has made it possible for them to attain gradually a real understanding of one another and to exchange valuable experience and special knowledge. Justifying one's point of view and testing one's theories in the light of friendly criticism may be made a process of growth.

A helpful use of the community's resources is seen in the cases of patients whose physical and social need is so involved as to call for the most skilful co-operation between medical and social agencies. The following example of the co-operation of a social service department, a dispensary physician, a consul, an immigrant aid society, a committee for homeless men, and the patient himself, illustrates better than any declaration of principle the value and effectiveness of a cordial and satisfactory working together.

Tony Milano, a bright faced Italian boy of twenty, wandered into a dispensary one day in June. He complained that he was losing his eyesight and that he was out of work because of that. This was the first time he had consulted an oculist. The doctor found on examination a detached retina in the right eye and a probable beginning detachment in the left. The prognosis was unfavorable. Tony needed daily observation in the clinic. As he had no relatives in this country to whom he might go while he was having treatment, a position was created for him at the dispensary where he watched the doctors' automobiles. This kept him in the open air and made it possible for him to see the doctor every day. He received careful treatment, to which his eyes responded very well, the vision in the left eye becoming almost normal. The ultimate prognosis, however, was unfavorable, and it was deemed best to send Tony back to Italy. There his family had a market garden where he could work out of doors.

Tony readily agreed to this plan although he did not know how he could get back. Also he was troubled because he had not responded to a call for military duty and feared that he might on his return be arrested and forced into service. As Tony was not fit to serve his country, even if his spirit had been willing, the consul was consulted. He gave Tony a large legal document asking for examination by military authorities in Italy, with a recommendation for clemency and hospital care if necessary. He also cabled the circumstances to Naples so that there could be no misunderstanding. Free transportation was furnished through the interest of the Italian Immigrant Aid Society. The agent of a Homeless Men's Committee was inter-

ested in Tony and secured for him proper clothes and the necessary money for the trip. A detailed medical account of the case was written to be presented to the physician in Italy, also a letter to the father, outlining the care that Tony should have to protect and preserve his eyesight. These letters were rendered into Italian by the Immigrant Society. When the day came for sailing, the social worker put Tony on board and interested the ship's physician in him. Six weeks later a letter came from Tony saying that while he missed his American friends and "the customs of our country," he was happy and contented and under a physician's care.

Conferences about difficult individual cases are helpful in meeting some perplexing problems. The expert social worker is always ready to give her experience and advice even if the problem is not transferred to her for solution. Such consultation between specialists is not unlike the cooperative methods prevalent in medical practice. The oculist, aurist, neurologist, orthopedist, pediatrist, obstetrician, and general practitioner, each working in his own special field, is still appreciative of the other's special knowledge and holds it essential to the honor of the profession to secure for a patient the advantage of the specialist's skill whether or not the patient himself has the ability to see the need. The general practitioner is able to determine when a specialist is indicated, but further consultation is often required to determine whether the general practitioner should thereafter

conduct the treatment under advice or whether he should pass over the case wholly to the specialist.

The hospital social worker should realize that she herself is somewhat of a specialist and that the scope of social work includes many other specialists. The associated charities or charity organization societies might be considered the general practitioners; their function is based on a wide general knowledge and on experience in dealing with family problems. So the children's societies are the pediatrists of social work. Each specialist is developing a kind of knowledge which should be at the service of the hospital social worker, who in turn should realize that she too has special knowledge to give.

Specialism, unrelated and self-centered, has its dangers. Specialism that appreciates its own field of work, sees its limitations, and calls others to supplement them, is like one of our bodily functions whose perfect coördination with the others produces a happy state of health.

CHAPTER IX

RECORDS

THE importance of careful and thoughtful case records in medical-social service should need no argument. To record the abnormal conditions of the individual in distress, the efforts put forth to eliminate these conditions, and the individual's response to those efforts, is as essential in social work as in medicine. Wherever we find a steady refinement of medical case records, with an increasingly accurate tabulation of essential facts concerning the patient's family history, past history, habits and present complaints, the physical examination, the progress of his symptoms, and the treatment, it is one of the most telling indications of an improvement in the quality of medical practice. Good medical practice depends on this careful and intelligent registering of the progress of cases, both as an aid to thorough examination and treatment in the individual instance and—through the collective study and analysis of such records—as a means of improving the care of future patients. The use of case records for teaching medical students is becoming an important means of instruction.

Two sorts of records are of interest for the present discussion,—the social and the medical. While social records have received a good deal of consideration from thoughtful social workers, they are less systematic in form and arrangement than medical records in hospitals. This is due partly to the fact that the professional technique of medicine is older, but also to the difference in the kind of material to be recorded. Facts noted in medical records are concerned largely with conditions that can be tested by instruments of precision, such as the thermometer, the stethoscope, and the microscope. With the development of scientific medicine, physicians have gradually discriminated between physical facts that are important and those that are unimportant in particular diseases. On the other hand, social conditions are to a larger degree dependent on personal interpretation, and thus accuracy is not so easily obtained.

Leaders in social work dealing with individuals in distress have recognized the importance of thoroughness and accuracy and have gradually evolved a technique of social examination and treatment. During the course of establishing this technique they have determined to some extent what facts are important to a good social record. The hospital social worker in looking for a suitable type of record for her work has therefore two types to study and to coördinate: (1) existing medical records (unsocialized); and (2) existing

social records so far relatively uninfluenced by the medical factors in the cases recorded. Neither type supplies her with just the form she needs, but each is suggestive and each supplements the other.

Some hospital social workers who find it difficult or impossible to limit the number of their cases to those they can deal with efficiently, deliberately allow their records to remain for a time unwritten because any attempt to keep them written up to date means the neglect of patients. But we cannot patch along in this way indefinitely; the work must be systematized. Another type of worker neglects records because the individual patient's distress is very appealing, while the record seems dry, dull, and academic. This is a superficial point of view and should never be tolerated by those responsible for standards in hospital social work. In every hospital, no matter how overworked her department may be, the social worker should keep before her the ideal for which she strives by writing out in a few cases, at least, a satisfactory account of her plans and doings. This accomplishment will spur her on, because it is a tangible reminder of the standard of work which she hopes ultimately to attain in all cases. By making a thorough analysis and giving continued consideration to a few recorded cases, we soon find that these are more intelligently and satisfactorily treated than are the unrecorded cases. Also, records furnish the most valuable arguments wherewith to convince trustees of the need for

more time for case work or the need of an increase of workers.

The confidential nature of records of social work should be recognized as essential. The records are necessarily intimate and personal. Unless there is a rigorous insistence on the protection of our records, we are betraying people's confidence. No worker has the right to secure the confidence of the patient, get the details of his story, and then set it down for the indiscriminate perusal of the curious. All records of social cases should be filed in cabinets that are kept locked except when a reliable person is in attendance. Access to the more intimate records should be given only to persons whose interest in the patient is justified—either for the sake of the individual patient or of someone else who may be in similar need.

In the course of an investigation by a state commission into the wages of women, a social service department was asked to allow the records to be used for study of the wages among women in industry who came to the hospital. In this way parts of records that are not too intimate may be examined for an impersonal study which is justified by its contribution to society's welfare.

Several types of records are in use in existing social service departments. The kind most commonly adopted is a general narrative following a uniform initial record sheet on which are tabulated the items most essential for identification and reference. In a few departments, notably

those at the Boston Dispensary, the Boston Children's Hospital, and the Union Hospital of Fall River, the family unit is the basis of the record; that is, the initial record sheet gives the family group and the patient merely as part of that group.* Additional individual records are made for each additional member of the family who becomes a patient.† In most of the other social service departments, for example, Bellevue Hospital and the University of Pennsylvania Hospital, the individual is the basis of the record.‡ The first plan is that generally used by social agencies dealing with families in distress; the second is that used by physicians writing records in medical institutions. There are varying opinions as to which form of record is the more practical and fitting for this new field of work.

Statistical and narrative records may be used for any or all of the following purposes, some of which have been previously mentioned:

(1) To aid the memory of the worker.

(2) To portray the conduct of the case so satisfactorily that a succeeding social worker shall have a complete history of all that has already been done.

(3) To aid the study of methods of investigation or treatment and to contribute to their betterment.

(4) To provide material for case-teaching as a

* See Appendix, p. 225. † See Appendix, p. 226.
‡ See Appendix, pp. 227–230.

means of instructing students in hospital social service.

(5) To promote medical-social research.

(6) To deepen and clarify the worker's reflections upon the problems that hospital social service encounters.

When records are used chiefly as an aid to the memory, some workers have found it best to jot down brief notes while at work, and later, at intervals of two or three weeks, to write or dictate from these notes a summary of what has happened. Such a record is helpful to the worker in charge of the case, but does not portray the successive detailed steps by which the work was done, and may be limited in its usefulness to a successor obliged to take up the work suddenly. Also, it fails to show clearly what methods of work are used.

The record which is most useful to those who study methods of work narrates in detail the steps taken in the progress of the case and gives, as well, occasional summaries of accomplishment. The occasional summary also has been found an aid in ready reference to different parts of the record, and a measure of what has been done. Such a summary should contain a brief statement of the most important steps taken, the results to date, and the problems still unsolved. All correspondence received and copies of important letters written concerning any case are often valuable for reference and should be filed with other data in the case folder. By careful attention to details of

procedure, lessons may be learned from either false or wise steps, and a knowledge of good technique thus secured.

The length of a record is not a test of its value. Neither does a copious but indiscriminate accumulation of facts constitute a good record; they may, indeed, only add confusion to an already complicated story. The essential details should be given as briefly yet as graphically as possible. A skilled medical-social worker will distinguish between the essential and non-essential facts in her records as well as in her work. In all six types of records careful distinction should be drawn between facts and impressions. The source of information should always be given. As the record proceeds, contradictory information may be recorded. The patient's point of view is often warped by ill-health and it is always important to distinguish between the facts and his own interpretation of a situation. There are sometimes intentional misrepresentations, the untruth of which appears only on further inquiry. The mother of a feeble-minded child gave to the doctor at the hospital a history of severe beatings and cruelty from her drunken husband previous to the child's birth. She also said that her husband was dead. These statements were recorded on the medical as well as the social record of this child. Further investigation, through the mother's family, through a physician who had known her for years, and through relatives of the father, proved that the

woman was below par mentally and morally; that the father had never been a drunkard, and that he was still living, although he had long since ceased to live with his wife because of her immorality.

Although all patients who are under the care of the social worker have physical needs, the facts necessary to understanding their problems are varied. The problem of the feeble-minded child or insane patient demands knowledge of facts not identical with those required for a wise handling of the problems of the tuberculous patient or the unmarried girl facing motherhood. Thus, uniformity in methods of investigation, and in consequence uniformity in social records, is impossible in the group of hospital social service patients just as in the cases of distress appealing to a social agency.

The initial record sheet adopted by a social service department is usually uniform for all cases. The narrative record following the initial sheet is varied according to the type of problem presented. The use of headings in the body of the narrative record serves as a guide in orderly report of significant facts and helps to give uniformity and consistency to the record.

The narrative record of a tuberculous patient should contain such facts as these: personal habits as to diet, sleep, exercise, care of mouth; knowledge of precautions against infecting others; health of relatives; history of previous attacks of pneumonia, bronchitis, pleurisy, or tuberculosis; home condi-

tions in detail, with special reference to dusty, dark, or airless rooms and other unwholesome surroundings as well as to the opportunities for proper home treatment; employment,—place, process, kind of materials handled, hours and wages; possible resources for carrying out the plan of treatment.*

The record of a child, on the other hand, should lay chief emphasis on the home conditions, school history, relation between parents and child, and possibility of securing co-operation with family.

Again, a record of a patient whose nervous condition is his chief source of difficulty calls for special information about the patient's heredity; his temperamental traits as interpreted by the patient and those about him; his relations with his family and those who make up his social circle. His own attitude towards himself, his work, and life in general, may also disclose facts of considerable value to the physician. All these phases of the patient's personality are factors studied by the neurologist in his private practice, but the limitations of time in hospital and clinic make it a practical impossibility for the neurologist to get at all these essential facts. Hence, by helping to get them, the social worker who is properly trained can be of great value.

Some types of cases which are to be especially studied or analyzed, such as occupational diseases, feeble-mindedness, or other diseases with social

* See Appendix, p. 231.

bearings, can be more readily and systematically recorded on definite, detailed forms or schedules. These schedules can be exactly adapted to the object of the inquiry, and their uniformity then makes a subsequent study much simpler and more consistent. One such schedule has been used in the social service department of the Massachusetts General Hospital for a medical-social study of all children who came to the medical clinic suffering with rachitis. The object of this study was, first, to aid the physician in discovering the social causes and complications of this disease; and second, on the basis of this knowledge to help make an effective plan of treatment.

A similar plan is being carried out with a study of gonorrhœal vaginitis in children at the Boston Dispensary and Massachusetts General Hospital. The complex of social and moral as well as physical factors in this disease makes it especially fitting that the study should include a search into all these aspects of it. Only on the basis of careful study from all three points of view can effective treatment or prevention be hoped for. All the patients were treated and studied simultaneously by the doctor and the medical-social worker. The patients could have no feeling that they were being investigated as types and ignored as individuals. Neither did the social worker suffer from the sense of helplessness common to students of social abuses who study the wrongs and must leave the wronged to their fate. Something

was done towards righting the wrongs discovered in every case.

Much of the investigation of occupational diseases has been directed toward the supposed connection between the occupation and the disease without regard to the personal habits and home conditions of the victims. If the way to be scientific is to be unprejudiced, we must in any search for truth consider all the known contributing causes. A hospital social service department might make important contributions to the elucidation of some of these social puzzles by bringing together expert knowledge of the bodily disease, the home, the habits, and the working conditions. In 1910 and 1911, the Social Service Department of the Massachusetts General Hospital carried on, with Dr. Roger I. Lee, a study of 80 working girls who came to the out-patient department suffering from diseases that indicated a prolonged debility.* Each girl was given a thorough physical examination and a social worker made a study of her habits, her home, and her work conditions. These accumulated facts in their interrelation were the basis of the study.

Dr. Lee's conclusion, that lack of opportunity for industrial training, for education in hygiene and thrift, was chiefly responsible for keeping these girls in poor health, was reached with a due sense of how difficult it is to brand any single fac-

* See Massachusetts General Hospital, Social Service Department. Sixth Annual Report, 1911.

tor as *the* cause. In co-operative research of this sort, only small beginnings have been made as yet; the future must show what benefit is to be found in this phase of hospital social work.

The use of records for statistical inquiry has been repeatedly exemplified in medical studies and social investigations. As the experience of hospital social workers increases, and as the volume of recorded cases is amplified, the records of these cases are sure to be examined much more than hitherto by statistical methods. Obviously such examinations depend directly, for any fruitful results, on the detail and accuracy of the original statements. No reliable conclusions can be drawn from a statistical study of unreliable data. Thus the hospital social worker should feel it her duty to put conscientious effort into the accounts which she writes of her cases.

Another value of accumulated statistics, particularly in the early stages of a social service department, lies in the demonstration which they offer of the work which the department is conducting. Pioneer workers have secured local telephones, stenographers, and additional workers because they have kept account of the number of times they have had to walk to the telephone on another floor, the time it has taken to write records and letters, and the pressure of new patients. Kind-hearted directors will often notice the tired face of the social worker and possibly urge a vacation, when the real need is a limitation of work or

increase of workers. However, the best argument for more help is a statistical statement of the bulk of the work. The supervising group, if they care for real efficiency in the department and have any conception of what social service demands of the worker, will be influenced by a graphic, statistical statement.

Most departments keep account of the new patients for the year, the number of old patients, the visits made, the nationality, age, sex, and illness of each patient, as well as of the sources from which they are referred. Some of the departments keep careful records of the extent of their co-operation with other agencies. Such statistics kept from year to year indicate not only the increasing extent to which these other social agencies serve the hospital patients, but they offer opportunity to consider the resourcefulness of the hospital social worker in doing the bulk of work that comes to her. Statistics that tell the true volume of the work; statistics that indicate any especially large problem, such as tuberculosis or children's diseases; statistics that show the use of other agencies by the workers,—all these help to tell the story of what the department is doing and what its policies are.

It is well to keep on file statistics that have been compiled from time to time, for the further reason that an analysis of the department's activities at a given time is made doubly valuable by comparison with previous figures. An accumulation of

careful records and accurate interpretation of recorded statistics may be made the legitimate basis for a plea for some special object. A social worker at the Washington University Hospital at St. Louis showed, through her accumulated statistics, that the crippled children who had come to the hospital for braces and supervision were not having any opportunities for education. She found that out of the children under the care of the hospital for one year, 102 were of school age but not attending school. Practically all of these children were in condition for instruction, but the long hours, the ordinary seats and desks in the public school, were not suited to them. The community that neglects the education of the crippled children is laying up for itself many future problems. This was the argument of the hospital social worker who urged for the cripples not only public schools for regular elementary teaching but also industrial training that would help the physically handicapped to self-support.

So far it has not been deemed convenient to file together the detailed medical and social records in any case. The medical records are filed in one room, the social records in another. Yet it has been found important that the doctor who is studying the medical record or treating the physical needs of a patient happening to be one of the few studied socially, should know that the social worker has also done some work on his case. The

additional data thus made available justify a remark or note on the medical record. Most social service departments have devised some such means of identification as stamping in red ink, "Social Service Dept.," on the medical record.

As the physicians realize more clearly the bearings of social factors on the diagnosis and treatment of disease, the number of social facts entered by them on the medical record increases. It seems to me that social facts secured by the medical-social worker and of importance to diagnosis and treatment should have a place on the medical record,—I mean such facts as a family history of mental disease, unwholesome occupation, peculiar traits of character, and habits. It must be granted, however, that detailed statements of procedure in the social conduct of the case would, if added to the medical record, merely make it impractical for ready use. The physician, who is and always must be chiefly concerned with the medical technique of the case, does not always find the details of social technique especially interesting. Neither are details of medical conditions and treatment required on the social records when the medical record is available. Means of identification, by cross references between social and medical records, will, of course, be always valuable.

The selection of such social facts as are pertinent to all medical records is now receiving the attention of some hospital physicians and hospital social workers. At the Lakeside Hospital in Cleveland

each patient admitted to the dispensary has his medical record filed in a folder on the outside of which are recorded the following facts: name, address, year of birth, civil state, sex, nationality, occupation, kind of material handled, and employer's name. This information is gathered for the benefit of the admitting officer and physician, not for the social service department. It is interesting to note that the item concerning occupation, with a statement as to the employer's name and the kind of material handled, is filled out by the physician examining the patient. Thus, the possible relation of the patient's disease and his occupation is brought to the doctor's mind. Many other hospitals have, as a matter of routine, recorded the patient's occupation in the medical record, but failure to appreciate the distinction between occupation and industry has rendered the item of little value. For instance, the occupation may be given as "laborer" and may mean any of fifty different kinds of work under that name. It may be given as "shoe factory" and mean anything from laster to packer. The dangers in these two kinds of work in the shoe factory vary greatly.

At the Boston Dispensary the medical records of several clinics contain social facts which the visiting physician has found, through his work with the social service department, important to his understanding of the patient's physical con-

dition.* Dr. W. Gilman Thompson of New York has devised an analytical record form for the clinical study of diseases caused by industrial poisons. This is being used at the dispensary of the Cornell University Medical School.

The development of medical records containing social data marks an initial recognition by the hospital of the importance of a knowledge of social facts to proper medical treatment. An interesting method of supplementing the medical record by social facts is to be seen at the Children's Hospital of the Boston Dispensary. The social worker, who sees each ward patient, secures a summary of the social facts, which is given to the doctor and incorporated in the beginning of the medical record.† At the end of the record appears a statement of the outcome, medical and social.

The hospital social worker, through her case work and her accumulated knowledge of social conditions, has constant opportunity to bring important social facts to the attention of the physician. She does well to feel her responsibility and recognize her opportunity. To make her contribution valuable, she must know her subject, for medicine is a properly conservative profession which accepts new types of knowledge only as they prove themselves of real benefit in the treatment of disease.

* See Appendix, p. 232. † See Appendix, p. 233.

CHAPTER X

ORGANIZATION

HOSPITAL social service, in the minds of its initiators, is not an independent enterprise, but an essential part of hospital activity. Those who first entered upon this branch of service believed that until the influence of social conditions on physical conditions is fully recognized and acted upon by the hospital management, medical efficiency is impossible there. But this truth had to be demonstrated before it could be accepted by hospital authorities and before hospital trustees could feel justified in expending their funds for the support of social work. This is natural enough, for many other initial experiments, such as those with kindergartens, playgrounds, school visitors, and school nurses, were made through the interest of persons willing to provide private funds. For like reason, when the initial social service department was established in 1905 at the Massachusetts General Hospital, it was carried on by private funds.

The principles on which the department at the Massachusetts General Hospital is based have been accepted by many as fundamental to thorough

hospital work. But the most suitable form of organization for carrying out these principles has yet to be determined. The relation of social service to the hospital administration and to the doctors; the methods of deciding what patients shall come to the department; and the best way of using the other social agencies in the city, are all details which are still in process of being worked out.

There are several forms of organization in use in social service departments today. This diversity has both advantages and disadvantages. The lack of uniform standards of work is a disadvantage, but, on the other hand, the opportunity to try out the effectiveness of different forms of organization is an advantage in these early stages of growth. Some forms have proved good, some poor, but none wholly destructive of the value of the service. It is as yet impossible to class any one as the ideal. There is, however, one conclusion that has been reached by all, independent of the diversity of their methods; namely, that *a social service department to be most effective must exist as an integral part of the hospital, not as an affiliated organization.* For the present this is impossible in some places, but it is the form of organization that is most likely to prevail in the end.

Of the organizations already existing no two are exactly alike. They may, however, be grouped under four general headings:

1. Those organized and controlled by the hos-

pital board; like the Social Service Department of the Boston Dispensary.

2. Those organized by hospital authority and affiliated with the training school for nurses; such as the Social Service Bureau at Bellevue Hospital, New York.

3. Those initiated by an individual or small group of individuals and supervised by a self-appointed committee recognized by the hospital; such as the department at the Massachusetts General Hospital, Boston.

4. Those initiated and supervised by an outside agency, such as the Associated Charities or a visiting nursing association; for example, the Social Service Department of the Buffalo General Hospital.

In any one of these four types of organization two principles are axiomatic: first, the most competent individuals to be found should be put in charge; second, a high standard of work should be required of the department by those who control and supervise it.

SUPERVISION

The question of supervision is an important one. If hospital social service were merely an extension of medical work, supervision by medical officers or nurses alone would be sufficient. But since hospital social service introduces a new element, not found in the technique of medicine, of nursing, or of hospital management, medical supervision of

social service should be supplemented by persons experienced in social work or at least appreciative of it. When the supervision is entirely in the hands of the medical profession, it may be successful in case the worker is well trained socially and the doctors, lacking special training in social work, are still sympathetic and ready to feel the value of a different point of view.

A very satisfactory form of organization, from the point of view of supervision, is that under the direction of an advisory committee, official or closely affiliated with the hospital organization, and representing the varying interests within the hospital and without. The Massachusetts General Hospital Social Service Department has such a committee, although the department is not as yet an official part of the hospital organization. It numbers among its members the superintendent of the hospital, one of the board of lady visitors, six members of the medical staff,—two medical men, one surgeon, one pediatrist, one orthopedist, one neurologist,—two trained social workers, and two business men. The diversity of experience contributed by such a committee is valuable and its discussion of matters important to the department is well balanced.

Social service committees, as they are frequently called, are often composed of women who have been interested in the hospital, through a ladies' aid committee or a board of lady visitors. They have been troubled by the sight of diverse social

needs among the hospital patients; hence they usually welcome the advent of hospital social service as an important aid. The St. Louis Children's Hospital has such a social service committee. In some instances the women on the committee have paid the salary of a worker and served as volunteers under her. But though these committees have supervision of the work in certain details, the ultimate control of policies usually rests with the hospital board. Such a group acting in a supervisory capacity contributes personal service and enthusiasm, but it may lack the advantages of the more diversified group in which the hospital physicians and trained social workers balance the point of view of the laity and bring expert knowledge of the complicated problems that come up for settlement.

Wherever hospital social service needs to be interpreted and explained to sceptical hospital authorities, and wherever it is dependent for financial support upon private sources, I believe that an advisory committee is of great help, even though the final control is still in the hands of the hospital. When standards of work have been evolved and generally accepted and when there are in the field thoroughly trained workers who can be given freedom to develop the department according to the accepted standards of social work, less responsibility for details will rest on the supervisory committee.

At the present time there are many elementary

social problems which from time to time arise and float about the hospitals unsolved. Not only questions of adjustment within the hospital and without, but also the fundamental question of what the hospital social worker shall do, remain unanswered in many hospitals. The type of case to transfer to another agency, the length to which a patient should be followed in order to fulfil the ideal of effective medical treatment, the kind of problem to recognize as insoluble by a given force of workers or with unsuitable facilities; the whole problem of how best to conserve the department's forces and put the best effort where it will do the most good,—all these matters must be threshed out before a satisfactory plan of social work can be constructed in medical institutions. Such questions should be considered by those who best understand both the ideals of the medical-social worker and the needs of the hospital.

SELECTION OF CASES

Various plans have been evolved for selecting from the whole clinic the patients who most need social service. The workers who deal with ward patients usually find that the desk where the admitting physician does his work is a strategic point for noting urgent social needs; as, for instance, in the case of a patient in need of immediate care in the hospital, obviously troubled because his family do not know that he is sick and because he does not know what will become of them during

his illness. Visits to the wards also reveal, through friendly talks with patients, burdens that the social worker can lighten. Through careful study of patients about to be discharged, the danger of a thwarted convalescence is now and then discovered. Many ward social workers question each patient about to be discharged and if home conditions are unsuitable for convalescence, arrangements are made for entrance to a convalescent home. The superintendent, resident physician, visiting physicians, and nurses often refer patients who seem to them to need the help of the social worker, but they do not always pick out those most in need of such help.

In dispensaries or out-patient departments, patients requiring social care may be selected in several ways. The admission desk is again a valuable point at which to learn about social complications. In several dispensaries,—the Massachusetts Charitable Eye and Ear Infirmary, Boston Dispensary, Cambridge Hospital, and Memorial hospital at Worcester, for example,—the social worker is placed at the admission desk. Her first duty, like that of the lady almoner in the London hospitals, is to pass on the question of admission of patients to free treatment by an inquiry into their financial status. In most instances she is also on the lookout for patients needing social service. It is of great importance to have at the admission desk someone possessing social knowledge and social sympathy.

The admitting physician who knows little of the widely varying standards of living among the patients, of the range of wages for various occupations, of the seasonal trades with their irregular incomes, and of the cost of living, has not a sound basis on which to determine whether or not patients applying for treatment are suitable for admission to a free clinic. Correctly to determine the fact of suitability for admission is as important as to discriminate regarding the clinic in which the patient belongs. It is no more possible to make a social diagnosis by seeing the clothes people wear than to make a medical diagnosis with one's eyes shut.

I once knew a patient who borrowed the best clothes of the whole family when she came to the hospital, out of a more or less conscious respect for the institution. She "looked as though she could pay," although in reality she was barely able to get along because of her irregularity in work and income and her precarious health.

In the third annual report of the Massachusetts Charitable Eye and Ear Infirmary of Boston some of the opportunities of the social worker at the admission desk are brought out:

"The Registration Department of a hospital, usually considered a cut and dried, most impersonal piece of work, is in reality the most interesting of the hospital departments. When you have asked a patient his name, his age, his birthplace,

his present address, his occupation and wages, you know a great deal about him. . . .

"Mrs. Antonio Luigi comes to the registration desk with little Tony, eyes much inflamed.

"'What is the little boy's name?' is answered fully, 'Tony Luigi, same his fada's name.'

"'How old is he?'

"'Nexta mont' tree year.'

"'Where was he born,—in Italy?'

"'Geno', ten mont' an' he come here.'

"'What is his father's work?'

"'Pick and shovel, but he no work now. He seecka da bed now tree week, seeck, alla time.'

"'Hasn't he had a doctor or gone to a hospital?'

"'No doct', no hospitale.'

"'What seems to be the trouble?'

"'Oh, he cough, cough alla time.'

"And when you have registered Tony, you know that he is one of five children; that his parents have been in America two years; that his father is a laborer, who has had irregular work; that the family has lived in three rooms in a crowded neighborhood on an average of $5.00 a week; and that the father is not improbably tuberculous."

Another social worker who has had experience at the admission desk says:

"The interest shown at the registration desk brings the patients back to it with a statement of their special difficulty or problem.

"Margaret Carney, a widow, fifty years of age,

lives in a nearby city. At the registration desk it is learned that she has been a mill worker but because of failing eyesight she has been unemployed for some months. The support of the family is a child, also a mill worker, who earns $5.50 a week. Later she returns to the registration desk to say that she is unable to pay for the medicines which have been prescribed by the doctor and she will be unable to return in two days, as he has asked her to do, because of the expense. Free medicine is secured for her and she is referred to a charitable society in her home city for the necessary help to enable her to return. This society wrote in reply that such help would be given her and that she is 'an old friend.' During a period of nine months she returned when it was necessary and her vision improved greatly, so that she was able to work when work was to be found."

It is at the admission desk that the social worker can get the pulse of the hospital, as the flood of humanity passes through her hands seeking the services of the institution. It may be her duty to know whence this flood comes and whither it goes. She may be commissioned to find out why and how the community uses such service as the hospital gives. Such a medical-social worker is placed at the admission desk of the Boston Dispensary. Her duty is not only to pass on the admission of patients to a free clinic but to be the student who analyses the dispensary population

in its social bearings. If, while admitting a patient, she learns facts that are of importance to the physician, she passes them on to the clinic. Her chief function, however, is in the field of medical-social investigation. It is for her to study the economic groups which the hospital serves, the question of "hospital and dispensary abuse," the alternative for patients refused admission to a free clinic, and the relation of the dispensary to other medical and charitable institutions. She may also guide medical-social researches, as, for example, in occupational diseases and industrial accidents.

In the majority of dispensaries the selection of patients referred to the social service department is left entirely to the physicians in the clinics. Slips similar to those used for prescriptions are placed in the different rooms.* When the physician finds a patient who seems to require social treatment, he indicates on the blank the physical treatment, suggests the social need, and refers him to the social service department. Such selections as these are more or less indiscriminate. The busy physician has neither the time nor the special knowledge to select those most in need of social assistance. On the other hand, if the social worker at the admission desk selects patients wholly by reason of what she learns on the social side, she is not necessarily selecting those most in need of medical-social work; her point of view towards the patient is too far removed from the considera-

* See Appendix, pp. 234, 235.

tion of his physical condition. What we need is a joint medical-social diagnosis of a patient's condition by the doctor and the social worker.

The practical working of such a plan can be seen at the small Children's Hospital connected with the Boston Dispensary. A social worker considers the social needs of all patients on admission. She visits the home of every child to see if the parents understand the child's trouble and to learn if conditions are fit for the child's return. She makes ward visits with the visiting physician and tells him of the home conditions she has found and of any plan she may have for the patient. She in turn learns of the progress of the patient's physical condition and the doctor's wishes for after care. No patient is discharged until the social worker, as well as the physician, has signed the discharge slip. Only those who have seen carefully considered plans upset by the thoughtless discharge of a patient without any notification to the social worker can truly appreciate the value of such close collaboration of the two factors operative in successful hospital treatment. A similar plan is being carried out at the Children's Hospital in Buffalo.

Although such co-operation is being tried in several other places, the Boston Dispensary has elaborated most thoroughly and consistently the method of using the social worker in the clinics, where she is as closely in touch with the doctors as are the clinic nurses. Here the social worker sees the patient first, and secures from him important

social facts which she passes on to the doctor.* With this twofold evidence before them, and knowing the number of patients that must be dealt with, they decide together what patients can be properly cared for by advice and supervision in the clinic, and what patients should be more intensively cared for outside the clinic by the social worker.

In a suggestive paper on the Social Aspects of a Medical Institution, read at the National Conference of Charities and Correction in 1912, Michael M. Davis, Jr., Director of the Boston Dispensary, pointed out that the next step in the development of hospital social service will probably be an adequate plan for selecting the patients who need social treatment in order to make medical treatment effective. He suggested that the social necessities of all who resort to a medical institution have never been measured and that any general estimate based on a comparatively small group of patients referred to the social service department is not sound. Basing his classification on a medical-social study† of the new patients coming to the Boston Dispensary on three different days, he has classified tentatively under four headings, the problems, social as well as medical, which present themselves:

"TYPE ONE. Patients whose social problems are evident and acute. These problems must be solved

* See Appendix, pp. 232, 236–237. † See Appendix, pp. 236–237.

promptly if the patient is to be in a position to receive any effective treatment.

Examples: A baby of fifteen months, ill-nourished, enlarged tonsils, pharyngitis. Mother a dish-washer in a restaurant, deserted by husband.

Married woman of forty, chronic arthritis of phalanges of right hand, scoliosis, teeth almost gone, severe headaches. Takes bromo-seltzer in large quantities. Cannot understand English. Three children at school, husband a tailor.

Young unmarried woman, illegitimate child. Both syphilitic.

"TYPE TWO. Patients whose social problem is not acute, but whose disease is one dangerous to others. It is a serious matter if a patient suffering from such a disease goes about without continued care and ultimate cure. The interests of the community in such a case are paramount to the needs or wishes of the individual patient.

Examples: Woman of twenty-one, recently married. Syphilis. Syphilitic throat lesions.

Married man of thirty-two, second stage tuberculosis; two children of school age and baby under two.

"TYPE THREE. In this type there exists no acute problem of poverty, ignorance, or employment; but examination at the first visit indicates a disease which means that the patient should return several times for treatment. Unless the work of the physician who makes the diagnosis is to be wasted, so far as service to the patient and the community is concerned, this return should be brought about. It is the duty of the institution to adapt its methods so that patients are most likely to return and so that the most economical

and efficient means are used for following up patients to such an extent as is necessary without squandering effort upon hopeless or unresponsive cases.

Examples: Man of fifty-two, married, no children. Clerk. Rheumatism.

Woman of fifty-three, married, two children, one at school and one working; husband a laborer, work unsteady. Indigestion and bad teeth.

Boy, age four. Father is a helper in a garage. Three other children, one working. Adenoids, hypertrophied tonsils, operative; dermatitis.

"TYPE FOUR. No acute social problem exists and treatment of patient can be completed at the first visit, or, if a few additional treatments be required, the disorder is such as to occasion discomfort sufficient to insure patient's return.

Examples: Toothache, requiring extraction; supposed need for eye-glasses, found on examination not to exist; stye on the eyelid.

"What is the relative proportion of these types?

"From a study at the Boston Dispensary I can say tentatively:

"Type One and Type Two (acute problems calling for medical-social case work): 25 to 30 per cent of all patients.

"Type Three (problems requiring social work but mainly by clinical methods): 40 to 50 per cent.

"Type Four (patients not requiring any following up or other definite social work): 25 per cent."

In explanation of this Mr. Davis goes on to say:

"These percentages are, of course, tentative even

for the single institution to which they refer. But I believe that this kind of classification is of fundamental importance to the social work of medical institutions. Such work falls into two main types, which for the sake of better titles I will call the 'case work type' and the 'clinical type.' To the latter very little attention has thus far been given. It seems that it would apply to one-half of all the patients, while the kind of work with which we are more familiar, the case work type, appears to apply to less than one-third. The clinical type of social work requires persons as well trained as those who pursue case work,—for most individuals carry on both kinds, though with different patients,—but the clinical work is not necessarily pursued according to those methods or with that point of view which has usually been regarded as effective in the care and rehabilitation of needy families in their homes."

On a careful study of Mr. Davis' results we may hope to base a new form of hospital organization which shall serve fully the patient's needs, both physical and social.

SUBDIVISION OF SOCIAL WORK IN HOSPITALS

Specialization of function has developed in most of the existing social service departments as soon as the number of workers has grown beyond the original one or two. Under the supervision of the head of the department, there may be workers in charge of tuberculous patients, sex problems, sick children, psychoneurotics, patients with venereal disease, cripples and the physically handicapped. When classification of patients to be treated by

social workers is made according to the physical disability, social treatment starts from the proper point.

These divisions of work do not necessarily correspond to the chief social needs of the institution. The call for a special worker for psychoneurotics may result from the interest of some physician who desires to refer to the department many patients who should have more than he can give them. A special worker for children, for unmarried mothers, or for the handicapped, may be placed in the department by some donor particularly interested in that type of unfortunates.

A wave of hopefulness—for example, about tuberculosis—leads to the appointment of some workers. Others serve a physician's particular interest; for example, in chorea. Others create their own position by the strength of a dominating personality. Yet all the while, hundreds of wretched patients may go quite unaided, not because we do not recognize their need of help, but because we are powerless to supply it. The pitiful group of alcoholic patients exemplifies this point.

In the more or less accidental and irregular forms above indicated social service has sprung up in more than a hundred hospitals since 1905. The social worker has usually made her greatest effort in whatever direction she found the superintendent, the doctors, or the nurses most sympathetic. This effort has often been neither satisfactory nor

systematic, and no one has felt this more than the workers themselves.

MEDICO-SOCIAL SURVEYS

We shall probably soon come to feel that fully as important as the establishment of social service in any hospital is a study of the social needs of the institution before social service is established. We should study the demand before we furnish a supply. Only recently, however, has such investigation been appreciated. The value of a preliminary survey, often applied in other fields of social work but rarely in hospitals, is an offshoot of the simple principle that one should know as much as possible of a problem before tackling it.

Partial surveys have already been made at the Boston Dispensary and at the Massachusetts General Hospital. These surveys have involved a critical review of the medical work of the clinics, over a significant period of time.* For instance, at the Eye Clinic of the Boston Dispensary, a study was made of the records of all the new patients who came to the clinic for three months in 1910 (263 patients) and again for three months in 1912 (301 patients). Social service was started in the clinic in 1911. In 1910, 66⅔ per cent of all glasses prescribed by the oculist were not called for. During a corresponding three months in 1912 only 8 per cent of the glasses prescribed were not called for. There was also an increase in the number of visits made at the clinic by the patients

*See Appendix, p. 238.

with iritis and keratitis. The number of visits per patient increased 50 per cent after social service was established. The number of patients cured increased from 9 per cent to 31 per cent; the number improved increased from 44 per cent to 55 per cent, while the number of patients lost sight of decreased from 37 per cent to 14 per cent

The object of a survey of the Mental Clinic records was stated as a means "to secure an impersonal self-criticism, gaining not only indications of the strength and weakness in the work but suggestions for the improvement of methods and attainment of results with a minimum of effort and expense." A second study was made after the medical-social worker had joined the clinic. Some of the significant facts brought out by these studies showed the value of social service to the clinic. During 1911, 59 per cent of the patients were lost sight of, while during the six months of 1912 covered by this study only 5 per cent were lost. During the first period, 80 per cent of the patients had "deferred diagnoses," that is, no diagnoses at all, while during the second period only 9 per cent had deferred diagnoses. It was also brought out that 40 per cent of the mental cases treated in the clinic during the second period were transferred to other institutions for care, as compared with 16 per cent during the first period.

A survey of the Children's Clinic at the Massachusetts General Hospital covered a period of six months from October, 1911, to April, 1912.

The study was made to ascertain a basis for organization of social work in that clinic.* The schedule sheet was formulated by the visiting physician with the co-operation of the social service department. One of the interesting results of this self-criticism was the revelation of the fact that the largest group of children coming to the clinic were under one year of age while the impression had existed that this was a "clinic of school children." Another fact brought out was that out of 779 patients, 426 came to the clinic only once. A further analysis of these 426 patients showed that they represented 59 per cent of the total patients suffering from improper feeding, 52 per cent of those with chorea, 56 per cent of those with bronchitis, 26 per cent of those suffering from heart disease, and 12 per cent of those with tuberculosis.

These surveys, although limited, have brought out clearly some of the haphazard methods now used in the treatment of dispensary patients and have indicated especially two needs: better records, and more systematic methods of following up the patient who fails to return. The results achieved in these clinics, while unsatisfactory, are probably as good as those to be found elsewhere.

These surveys have also given us a rough test of efficiency in dispensary service and have brought out some defects that can be and are being rectified. Every step in the growth of hospital social service

* See Appendix, p. 239.

emphasizes the necessity of making the department an integral part of the institution, identified with all the community relations of the hospital. Social workers should help to keep fresh in the minds of all who work within the hospital walls the consciousness that it is not the separate but the combined results of the hospital activities which are far-reaching and essential to the well-being of the community.

CHAPTER XI

WORKERS

THE choice of workers is the most important consideration in the development of a social service department. The qualifications desirable in a worker are those needed to bridge the gap between the community and its servant, the hospital. She can make each more conscious of the other, and can guide each to draw more fully upon the other's resources. Social work has been carried on most pleasantly in some hospitals without stimulating either the work of the physician or that of the social agencies in the community. But this is not the kind of social work we are discussing. Often the only gain has been a little more kindness to the patients confined in the hospital. Without underestimating the value of personal kindliness in an institution where it is so desirable, I wish, nevertheless, to point out that it is only one aspect, not by any means the whole, of hospital social service. A physician connected with a hospital that "had social service" testified that he knew of nothing that the worker did except to visit the ward in the capacity of a friend; he had never "come in contact with her in his

work," and could tell little about her value; he believed she was much appreciated by the patients. Skilled social work, like nursing, includes acts prompted by kindly interest; but it should include far more. A social worker who has failed to give some, at least, of the physicians in the hospital a sense of her value, in helping to secure effective treatment, has failed to perform the sort of service which is considered in this book.

The social worker must sometimes be a disturbing element if she is to make her proper contribution to the establishment of social work in a hospital. Any innovation in a conservative institution is likely to be a bit disconcerting, not in the sense of producing useless irritation but by disturbing some old habits. The worker should have this quality of stimulating without annoying others, both within and without the hospital. If she is to be the head of a group of workers, such a gift will be invaluable. If she is to be the only worker, it may enable her to gather helpers about her or to inspire in all who come in contact with her the desire to help.

A hospital social worker should have these among her more special qualifications: First, she should have the technical skill of the social expert, and the ability to adapt that skill to the needs of a medical institution. Next, she should have tact and such understanding of the physician's habit of thought as will enable her to approach him on the professional side so that he

will not be jarred by the sense of an "outsider" in his clinic. Third, she should have the initiative and imagination that are necessary to introduce the social point of view into the hospital; she should also have the power to insist that the social point of view, as well as the medical, receives its due recognition. Fourth, she should have the instincts of a teacher, but also the receptiveness of a student. She should have organizing ability, open-mindedness, and, last but not least, a sense of humor. This may seem like a catalogue of impossible virtues; it is difficult to find them all in one person, but it is not hopeless. These abilities can be in part acquired through training, but to a larger degree they are necessarily matters of native endowment. Possessing them, the worker will not only bring efficiency to her daily tasks, but she will remain sufficiently plastic to increase her efficiency through experience.

In the head worker many qualities are desirable, but among them three may be selected which are of especial importance: a trained social point of view, executive ability, and a discriminating open-mindedness. If there is to be but one worker, the task of choosing her is more difficult than if she is to be one of a group. A group of workers may be so selected as to supplement one another's qualities and thus bring to the department the variety of qualities that is desirable. For instance, the trained social worker without medical knowledge and the trained nurse without social knowledge

have several times done splendid team-work, each having a due appreciation of the other's contribution to the department. For the pioneer worker, steadfastness of purpose and patience are most helpful assets. No matter how much she may bring to this new field, she has to win her way step by step; for in no hospital is the way wholly clear for the establishment and conduct of a social service department. While there may be many who sympathize with her efforts, there are always others who are not interested. There may even be some who are antagonistic, who regard her advent as an unwarranted criticism of a "well-ordered institution" rather than as a promise of increased efficiency. But consistent, thorough work will finally have recognition, and the pioneer efforts that are wisely guided always justify themselves within a few years.

The ability to co-operate easily with the physician is necessary for various reasons. First of all because, as already noted, social work is nothing more than a superstructure upon a foundation of good medical work. To build well on this foundation the medical-social worker should have a sympathetic understanding of the well-seasoned purposes and often disappointed hopes of medical treatment; and she should know how to reinforce them. She should also make the physician increasingly acquainted with her plans and efforts for the patient. In talking with physicians she should be constantly mindful of their busy lives,

and should avoid all unnecessary interference with the routine which saves their time. Physicians are most generous in explaining physical conditions to the hospital social worker who has not special medical knowledge; they are beginning to recognize, in turn, that they must often learn from the social worker the significance of social diagnosis and treatment. Doctors, nurses, social workers, and patients are alternately teachers and students, giving and receiving according to their lights.

If the hospital social worker is to be the community's interpreter, if she is to remind the institution she serves of its external relations, she must hold these points of view distinct in her mind. She must see the hospital from the point of view of the laity, as well as the community from the point of view of the hospital. She should live as nearly as possible the wholesome life of a citizen, and continually strive to see the hospital as it looks to the stranger within its gates. On the other hand, her understanding of the huge, complex, and busy institution will often enable her to interpret to outside charitable agencies some of the mysteries and paradoxes of hospital rules, which they do not readily appreciate. The necessity for "red tape,"—the admission, classification, and discharge of patients; the physician's professional point of view, his secrecies, points of honor, and habits of order; the custom of sending ward patients away as soon as their recovery is sufficient to

permit it,—is a feature of hospital management which is likely to be misunderstood. A reasonable explanation of these conditions will often help to foster good feeling between the hospital and the people outside.

In order to co-operate wisely and effectively with other social workers in the city, the hospital social worker must be able to appreciate their functions and to work side by side with them. Only thus will they learn her functions. Also, it is by keeping closely in touch with the social workers outside, by reading current literature on social problems, and by seeing clearly her work in its whole significance that the social worker in a hospital can continue to contribute her part to the solution of institutional problems. Nothing is more easy and more deadening than to drop into institutionalism. Habit and routine are the methods by which we gradually simplify our oft-repeated actions, and allow their performance to be controlled by unconscious mechanism. It is of prime importance for the medical-social worker to keep herself from getting into habits that blind her to any aspects of the patient's life that are fresh and acute to the patient himself as he comes to the hospital for the first time. His dislike of smells, bare walls, white coats "like butchers," his fears that neighbors will find out what is written on the hospital record, his dislike of nursing by women not of his own family, are often forgotten. By reminding herself con-

stantly that each patient has many interests and ties other than those associated with his disease, the worker can best preserve fresh and vivid her social point of view. Thus, while appreciating the attitude of the physician and of the hospital authorities, she must always keep clearly in mind the feelings of the patient whose representative she is.

In organizing her work for its greatest effectiveness, she should become acquainted with the town or city in which she is placed, and its activities both within and without the hospital. She should know her special problems as they are presented through the patients she serves, and the special resources in the community for meeting those problems. It is wise for her to start her labors in that ward or that out-patient clinic where she can most surely hope for response and enthusiastic co-operation. But from whatever point she starts she should aim finally to have the social work so permeate the institution as to lose any sharp delineation of its field. While she must always be the agent through whom a special work is to be accomplished, the spirit of social service should become that "integrating factor" that binds all functions of the hospital together.

Social service alone can never accomplish this; it must result from the co-operative effort of all concerned. To the social worker, however, the opportunity is often presented of weaving together many of the strands. She sees the patient in his

relation to the admitting physician, the visiting physician, the nurse, and the visiting clergyman, and can help each of them to know what the whole man needs.

Social service entails upon her the use of a plastic organizing faculty. Nothing defined and preconceived can be superimposed upon a hospital or dispensary. Each medical institution is different from others in its organization and needs. Social service, as a supplementary element, should fit into the organization as easily as possible. The worker must accept the situation as she finds it, and so develop her function within it that she shall accomplish her end with as great effectiveness and harmony as possible.

Probably no question with regard to the choice of workers has been more discussed than that of the fitness of the trained nurse for medical-social service. While the value of some of her special knowledge is not called into question, there has been a difference of opinion as to her fitness for this service by virtue of her nurse's training alone. It is contended that since hospital social service deals with sick patients, the nurse is peculiarly fitted for this service. That she may have the ability to work smoothly with the other nurses and with doctors, that she may have keen human sympathies, and that she may have a social point of view are granted; but that she can possess and use the technique of social work without having

had experience or training in that special field is obviously not probable.

After the technical clinical training which the nurse receives in two or three years of confining, arduous study and labor within the hospital walls, she will still need a knowledge of the community and its resources, an appreciation of the various standards of living represented among the hospital patients, a familiarity with the habits and prejudices of various nationalities, and especially a knowledge of the ideals and methods by which constructive social work is sustained. This knowledge should be a part of her equipment before she can do the best social work for the hospital.

There are fundamental differences between nursing and social work. The relation of a patient to a nurse is one of dependence. If the patient is sick enough to need a nurse's care, he must be spared all responsibility and give himself up to the physician and nurse who seek to restore him to well-being. Most nurses become restless during the convalescence of a patient. Their technical ability, which they naturally enjoy using, is no longer called upon. During convalescence the needs of a patient become changed. He must begin to depend on himself; the habit of dependence must be broken and a constructive effort made to help him toward self help. The nurse, unless she is one of the comparatively few who have had experience in teaching, has little preparation for this service, because patients rarely complete

their convalescence in the hospital. When she no longer feels that the need for her personal, skilful aid is urgent, the inspiration for her work is gone. It is partly because of a natural characteristic, the desire to be needed, that women have been such successful nurses, and that nursing will always be one of the greatest professions open to them.

While social work is by no means a greater or a nobler service, it has quite distinctive aims. Good social work is constructive, for its conscious aim is the independence of the beneficiary. It strives to prevent the dependent applicant for charity from submitting to contributed aid; it also strives to make him do what he can for himself. Herein lies the present distinction between nursing as it is practiced in our hospitals and social work. Again, from a consideration of the patient as an isolated individual whose personal abnormality must be rectified, the social worker must learn to consider the individual in all his human relations. As a nurse, she must fix her attention on the troubles of one person alone; as a social worker, she must see the patient's illness as only part of a larger and more intricate difficulty,—the key perhaps to a house of sorrows. The outlook becomes divergent rather than convergent, and new and different points of observation are called upon. This does not mean that nurses cannot and have not developed into efficient social workers. There are many such; but our training schools for nurses alone have not produced them.

The nurse has not only to acquire new abilities, but to overcome old tendencies, the result of her special training, before she can succeed in social work. The desirability of originality and initiative in social work is apparent. The training of the nurse, as it is carried on in the majority of our training schools, does not stimulate these powers, for a prolonged period of silent submission to discipline is characteristic of her training-school experience. She does not learn to think independently, to dare, to lead. As a social worker, however, her position is not one of subservience to orders. Rather is it one of independent judgment and constructive planning in her own sphere. Her decision with regard to the social aspects of a situation, and her formulation of a plan of treatment, must be an independent contribution. The final decision will not rest wholly with her nor with the physician, but will grow naturally out of the balancing of the two points of view. Neither takes orders from the other. To the nurse this involves a necessary shifting of her habits of mind. She is no longer the doctor's medical assistant, but his consultant, called as an expert from another field of service.

The trained social worker who has no medical knowledge, is also handicapped in hospital social work, although she will find her social knowledge and experience essential in such work. She has much to learn concerning physical conditions before she can work intelligently. In fact, medi-

cal knowledge is an important asset to the social worker wherever she is. There is at present no means of getting just the kind of medical knowledge that is needed except by daily contact with those who will pass on the necessary instruction. Time may show that much of the technical bedside training of the nurse is unused in social work, and that much definite medical knowledge concerning causes and progress of disease, treatment of long convalescence, sanitation, significance of predisposing causes for disease (as fatigue, malnutrition, etc.), special knowledge of tuberculosis, of contagion, hygiene, and public health methods, —all vitally important in social work,—are not emphasized in the nurse's training.

A special course for medical-social work is needed, and so a new profession may be developed. The nursing profession is an outgrowth from the medical profession. The medical subjects valuable to bedside service have been given rather grudgingly to the nurse and have been supplemented by special methods devised to make the patient more comfortable through the nurse's personal care. In the same way, the profession of the hospital social worker, which is neither medicine nor nursing, will have to receive from medicine those aspects of medical knowledge vital to its new function, supplemented by special knowledge from sociology. Workers so trained would have some comprehension of two professions, which would make them valuable both in medical

and social problems, and helpful to the patient both in his physical and in his social difficulties.

For the present, the lack of properly trained women has thrown upon the social service departments the responsibility of sending out workers, inadequately prepared, and after only a few months of preliminary training, to establish similar departments in other hospitals. The lack of standards that has become apparent as a result of this use of untrained people sometimes seems to jeopardize the best interests of the whole movement. Nevertheless, a large measure of success has attended the hospital social worker wherever she has been established. She has met a need, although imperfectly, and demonstrated the importance of the place she is called to fill.

VOLUNTEERS

As I have previously stated, volunteers from the laity and clergy had long visited sick patients, and tried by devoted personal service to meet their material and spiritual needs, before professional social service was thought of as an integral part of the care of hospital patients. The service of volunteers, therefore, cannot be regarded as an innovation. Neither should we regard it as supplanted, but rather as made more effective, through the advent of the professional social worker. Both in the wards of the hospital and in the out-patient clinics, the social worker, being officially recognized and trained to observation, has special opportunities

which enable her to discern the needs of the patients more accurately than can be done by the untrained volunteer. Her constant opportunity for discovering obscure difficulties and distress will give a still wider field of usefulness to the volunteer than was ever before possible.

In some hospitals, volunteer service in the wards has remained independent of the social service departments, the work of the professionals being largely confined to the dispensary. Such loose organization and such division between two groups performing so nearly the same function in the same institution indicate a distinct weakness. Not only are overlapping and duplication possible, but each group misses the peculiar contribution which the other has to make. An organization by which the paid social worker, in virtue of her official position and special training, supervises and guides the work of the volunteers brings the best results in the end.

It would be difficult to estimate the measure of helpfulness that has been contributed by volunteers since the organization of social service departments. The enthusiasm and devotion with which they have co-operated with the trained workers has been a great stimulus and support to those who carried the responsibility of the pioneer organization. Not only have they helped materially in the day's work, but they have also conveyed to the hospital authorities and to those in the community from whom support is drawn,

an appreciation of the importance of the department. Highly efficient professional social workers have been trained in the volunteer group.

In hospital social service the distinction between paid and unpaid workers is not necessarily that between trained and untrained, for many volunteers are as competent and experienced as paid workers. Many of the volunteers have, from the beginning, been in close touch with the details of the department's activities. Especially is this true at the Bellevue and the University of Pennsylvania Hospitals. They have worked shoulder to shoulder with paid workers. The result has been a growth in their experience and ability until in some hospitals they may help, under sympathetic guidance, to stimulate and to contribute valuable aid in every division of social work.

There are several cautions to be observed, however, in the selection and direction of volunteers. In the first place, care must be taken to prevent their number being too large for careful supervision of the details of their work. If the number increases beyond the ability of the trained worker properly to supervise and develop the efficiency of the volunteer corps, volunteer service may become a weakness rather than a strength. In cities where the hospital social work has become popular enough to excite the interest of persons who can give volunteer service, the paid worker can select from the various applicants those whose service will mean most to the department.

There may be among the applicants some who do not seek personal relations with patients, but who are especially fitted for statistical or clerical work. In one department a volunteer assumed the tabulation of all routine statistics that were kept by the department; another took charge of the catalogue of the locations from which patients come. It is only just to the patients and to the volunteers themselves to take pains in their selection and in fitting their tasks to their abilities. Making them responsible for a piece of work and holding them to a high standard in it is by far the most satisfactory arrangement for all concerned. There is no satisfaction to the helper in work poorly done, nor in uselessly wandering along without guidance. Imagination on the part of the paid worker in discovering ways for employing the special gifts of her volunteers multiplies her usefulness. Some can be of great service in the details of office work; some are well fitted to interview patients; some undertake correspondence with patients, writing friendly letters to those who are leading a tedious existence in a sanatorium; and others are well suited for visiting the patients in their homes. To study the capacity of each applicant and then to give each an opportunity, under direction, to make the fullest use of her capacity, develops the most efficient corps.

Certain conditions should be insisted upon with all workers, volunteer as well as paid. Promptness and regularity are essential. A schedule of

the volunteer workers, with the hours at which they are responsible to the department, is indispensable; and it is equally indispensable that the volunteers should keep to their schedule. This is particularly true for the volunteers who give service in an office where desk room is limited, and for whom work must be planned out in advance. Those who undertake such work as making a home visit, or arranging for the transfer of a patient to an institution for convalescents, need not be held so rigidly to stated hours. In the case of volunteers acting outside the hospital, a written report of what has been done, noted briefly and concisely and given promptly to the paid worker, offers opportunity for both the paid worker and the volunteer to consider together what has been done. As the variety of work and responsibility placed upon volunteers increases, such reports mark the progress of the volunteers' development.

The supervision of volunteers should be painstaking, especially of volunteers visiting patients in their homes. They should not be asked to take the full responsibility of such cases, even though they be the only persons coming directly in contact with the patients. That is unjust both to the patients and to the volunteers. The final responsibility for all activities of the department must rest upon the paid workers. Some paid worker should be intimately acquainted with all the service of the volunteers, so that what they are doing may be known to the department and can

be closely connected with the physical treatment planned by the doctor.

A helpful way of eliminating the repetition of personal instructions to new volunteers is to have a notebook of instructions which each new volunteer can peruse when she first comes to the department and can consult from time to time. Information, such as the names of the hospital officials and members of the social service department, hours for admission of patients and for visiting in wards, rules governing the care of records, location of maps, street directories, writing supplies,—in fact, any kind of information that should be common knowledge among the workers in the department and that will help to make the department's work simpler, will be found suitable for such a book.

A weekly conference between volunteers and paid workers is an admirable way to give volunteers valuable experience and to give them insight into hospital social service. Such a conference gives opportunity not only to discuss the difficult problems of some of the individual cases, but to indicate the fundamental principles underlying the analysis and treatment of all the cases.

Many times the workers feel the need of help from professions other than those available in the hospital, the help of the lawyer, the minister, the psychologist, and the linguist. Every community has members of these and other professions ready to give volunteer service to those in

trouble. It rests with the social worker to find them.

Sometimes students of medicine, of divinity, of economics, and students in schools for social workers have given useful volunteer service in the social service department of a hospital, while obtaining valuable experience for themselves. Dr. Emerson's employment of medical students for social work in order that they might get an appreciation of the social side of their patients' lives suggests a way of increasing the number of helpers. A divinity student offered several hours each week to a social service department, saying:

"If I am to be of any use in the ministry, I must know more intimately than I do the kinds of trouble that people have to meet. It seems to me that hospital social service would give me the best opportunity to know how to be of help in every kind of distress."

In New York, Chicago, Boston, and St. Louis students from the schools for social workers are assigned to hospital social service departments for practical work. Such students thus have opportunity to gain experience analogous to that which the medical student has in the hospital clinic. The value of the experience depends on the fitness of the student and the kind of supervision given. If the student is truly interested in hospital social service, and if regularity, conscientiousness, and accurate reporting of all work done are demanded of her, she should complete her relations with the

department with a clear conception of what hospital social service is and with an idea of methods and standards which ought to be valuable to her in any field of social effort. Such experience is, of course, limited, and is designed only to give the student a glimpse of medical-social service so that she may have an appreciation of the hospital worker's function. This should not be confused with a special training for hospital social service, such as that now offered at the New York School of Philanthropy and at the Boston School for Social Workers. The special course at the Boston School offers several months of practical work under supervision in the Social Service Department of the Boston Dispensary or the Massachusetts General Hospital. Problems in case work, record making, and organization are discussed in weekly conferences, and a course of lectures on medical subjects of social significance is attended.

Hospital social service, as it develops, must take form from the personalities of those who are molding it. For this reason, the choice of workers, both paid and volunteer, must be considered of prime importance. Workers who are carefully selected for ability in organizing and interpreting the work, and who possess a balance of qualities fit to meet the multitudinous needs of the service with a never-failing spirit of sympathetic interest in the patients, will bring the best promise of success.

CHAPTER XII

THE FUTURE OF HOSPITAL SOCIAL SERVICE

THE hospital social service movement is a part of that stirring of hearts and minds which presages the awakening of our social conscience. The movements for industrial welfare and for the elimination of child labor; the campaign for moral prophylaxis; the awakening of the churches to a larger usefulness; and the growing interest in a eugenics program partake of the same spirit.

These movements are fundamentally based on a belief in our moral responsibility for one another. "Prevention" and "efficiency" are their watchwords, and the spirit of social service is their impelling motive. Hospital Social Service is then the tangible evidence of the working of the social conscience in the hospital. While it will always express itself tangibly in the activities of hospital social workers, its influence is likely to spread beyond the institution and make contributions to medicine, to nursing, and to general social work.

HOSPITAL SOCIAL SERVICE AND THE HOSPITAL. A lasting contribution of hospital social service to the institution in which it is conducted can be made only when that service becomes an expression of forces within the hospital. The initial stimulus may come from without, but no vital social work for the institution can result until the principles of hospital social service are so implanted within the institution that growth from within is assured. Those in control of the hospital activities—the officers, physicians, and nurses—must have a social interest before their institution can become socially efficient in any measure approximating the ideal. For many years past, the real interests of most medical institutions have been concentrated on the perfection of their professional technique, on the efficiency of construction of buildings, and on the economics of hospital management. This phase has been that of the institution's youth. Youth is necessarily the time dedicated to self development and to acquiring the tools of experience, and it is inevitably accompanied by a self interest which is as unconscious as it is transient. When the tools, whose use has been thus laboriously attained, begin to be tested on the real issues of life, and their efficiency questioned, the period of youth passes. The idea of hospital social service expresses this very maturity of hospital experience, for it asks whether this "perfected hospital technique" does after all give effective treatment to patients. Such a question

does not express a desire to change the function of the hospital, but to develop it; not to insist that the tools be rejected, but that they be more exactly fitted to the work they are called upon to do.

HOSPITAL SOCIAL SERVICE AND MEDICINE. For a long time skilled hospital physicians, especially dispensary physicians, have seen that many of their painstaking efforts have been futile so far as their real value to the patients was concerned. Hospital social service has presented itself to them as an aid in so rounding out their work with the individual patient as to justify the effort and expense involved in medical treatment. The natural result is going to be an embodiment in the technique of medicine itself of many of the methods characteristic of the best social work. The hospital physician will find it more and more impossible to ignore the psychological and social elements of his patient's troubles. He recognizes that he cannot treat a disease of the kidneys without reference to the heart, the digestion, and the nervous system. He is beginning to feel that he cannot treat headache without a knowledge of a man's work, home conditions, sleeping habits, and economic anxieties. He will not become a social worker in the technical sense, but he will use the methods of this closely related profession more and more freely as he learns their medical value. Even if we never get any further than where we now are, hospital social work may feel that it has at least thrown a new light upon the

practice of medicine in hospitals and dispensaries, and brought into the foreground some facts vital to medical knowledge that were in semi-darkness.

Hospital social service has come in on such a high wave of enthusiasm that it has run some dangers. To its friends it seemed to embody so vital a principle, to be so appealing and so practical, that they felt no necessity of its advancing cautiously and justifying each step of the way. Some of the most helpful friends of social service have been those who at first were skeptical about its value.

The conservatism of medicine is its protection against quackery. Before it can be generally accepted hospital social service must prove that it is neither a medical nor a social fraud. It should not pretend to be the cure-all nostrum that introduces human feeling into the "heartless" clinic, but should recognize that kindly interest in human beings is nothing new to the medical profession. Hospital social service extends the humanity of the hospital, but cannot boast of initiating it. Neither should it feel that a social diagnosis is more important than a medical, but that it is supplementary and helps the doctor form a plan of treatment within the range of the patient's possibilities. What it may rightly take pride in is the privilege accorded it of forming out of elements in the two great professions of medicine and sociology, a new profession. This is a pride, however, that conduces to humility rather than to vainglory.

HOSPITAL SOCIAL SERVICE AND MEDICAL SOCIOLOGY. Medical sociology, the science of the interplay of medical and social elements in human society, is looking for laboratories in which to study its problems. The study of occupational diseases, alcoholism, blindness, tuberculosis, and immorality, is rapidly engaging the attention of medical and social experts, who are looking for the best sources of material and the most suitable conditions under which to make their investigations. Hospital social service departments offer ideal opportunities for the conduct of medical-social clinics. Patients file by, day after day, victims of all the tragedies of solitary struggle and of community life. Social workers chafe at the futility of their efforts at repair, and long for a campaign of prevention. They soon realize, however, that the task of prevention is more complex and involved than medical-social treatment.

Campaigns of education, which are the chief weapons of prevention, must be preceded by careful analysis of the various contributory causes, and of the possibilities for effecting a change. Here is the work of the expert in medical sociology. Social service departments can perform a great function by serving as laboratories for the students who try to "learn of life from our mortality." The Social Service Department at the Massachusetts General Hospital has attempted to answer by careful investigation the question, "Why do working girls become so debilitated that they are forced

to come to the hospital?"* The Boston Dispensary has established as a member of its social service staff, a medical-social investigator who will serve throughout the year.

All these signs point to prevention as fundamental in constructive medical or social work. Of course shiftlessness, broken legs, and sick babies will still be with us even after the elimination of hookworm disease, the control of dangers from industrial accidents, and the extended education for motherhood. Although we cannot hope that preventive measures will wipe out all our medical-social problems, we can be sure that education will slowly and surely remove many of the causes of physical distress as we see them today. To have a small share in this service is the privilege of the hospital social worker, for through the education of the individual patient and the recognition of the significance of the day's work she may find large opportunities to make her contribution. A valuable research into social conditions surrounding cases of ophthalmia neonatorum was conducted by Miss Catherine Brannick, Social Worker of the Massachusetts Charitable Eye and Ear Infirmary of Boston; the results were published in her Second Annual Report (1910). The facts which she presents constitute a very legitimate appeal for the helpless baby, facing the possibility of blindness, and suggest innumerable possibilities

* See Massachusetts General Hospital, Social Service Department. Sixth Annual Report, 1911.

for the hospital in bringing vividly to the attention of the public the social burden of disease.

Occupational diseases are beginning to attract to an increasing extent the attention of physicians and sociologists in the United States. Some investigations of occupational diseases are best made in the factory or work-shop, but other opportunities for such studies should not be overlooked. The hospital and dispensary are continually caring for victims of industry without any consciousness of the significance of the patient's diseases. In a Symposium on Industrial Diseases in June, 1912, Dr. W. Gilman Thompson pointed out some of the opportunities in hospitals and dispensaries to study such diseases. He also presented a classification of occupational diseases and made suggestions as to the possible function of hospital social workers as agents in these studies.*

Dr. Richard C. Cabot also has indicated the chances which hospitals and dispensary clinics offer for the study of industrial diseases.† He argued that the position of hospital physicians is strategic for an unbiased view of medical-social conditions. So many incidental products of industry pass through the hospital that the socially-minded physician can find abundant material close at hand. When he realizes his opportunity, he can

* Thompson, W. Gilman: Classification of Occupational Diseases. *American Labor Legislation Review*, June 12, Vol. 2, No. 2, pp. 185–191.

† Cabot, Richard C.: The Function of Hospitals and Clinics in the Prevention of Industrial Diseases. *American Labor Legislation Review*, June 1, 1912, Vol. 2, pp. 293–296.

do a great service. The thoroughly trained hospital social worker as agent of the socially-conscious hospital, reflecting the scientific attitude of the medical profession and bringing to medical conditions the special knowledge of the social worker, has opportunities for research which have not yet been fully appreciated.

Beginnings have been made in the study of industrial diseases coming to the knowledge of the Social Service Department of the Massachusetts General Hospital. Patients suffering from lead poisoning who had been treated at the hospital are being sought out by medical-social workers to ascertain what the definite occupation was and the mode of poisoning. It was found that among the patients treated during a period of five years, 147 cases of plumbism were recorded. A preliminary study of the medical records showed the lack of important social facts in these cases, but also indicated the unusual opportunity that medical institutions have for taking account of the social importance of cases treated. If accurate description of all occupational processes could be obtained in cases of lead poisoning the hospitals could offer valuable material to those who are seeking for better labor legislation and enforcement of industrial hygiene. "Laborer" means nothing to a physician who is examining a specimen of blood and finds a "marked stippling" (suggesting lead poisoning), but when he learns that this laborer is a scaler of paint in the hold of a ship in the navy

yard, he has new evidence as a basis for his diagnosis. Also a consciousness on the part of physicians of the relation between the patient's diagnosis and his occupation might make it probable that no patient treated for lead poisoning would leave the hospital without knowing why he was sick.

In research as in all other aspects of hospital social service the foundation of careful medical work is essential. With this as a basis, the hospital social worker who in the spirit of scientific medicine seeks for the social backgrounds of disease should be able to help considerably in the progress of medical sociology.

HOSPITAL SOCIAL SERVICE AND THE MEDICAL STUDENT. All the progressive movements for public health and social welfare need the socially-minded physician. Such doctors as Henry B. Favill, Prince A. Morrow, Henry J. Gerstenberger, and David L. Edsall are the mainstay of the campaigns against tuberculosis, venereal disease, infant mortality, and occupational disease. The social-mindedness of doctors, however, is not given them by their medical training. Rather do they get it, if at all, through their natural interests and through the conviction, forced upon them by years of medical practice, that medicine and sociology cannot be divorced. Society should not have to depend upon the chance production of this most valuable type of physician; the medical schools should assume the responsibility of producing

them. Medical schools cannot teach psychology and sociology, of course, though they might demand preliminary training in these subjects during the years of college preparation. But clinical teachers can so bring out the significance of social facts in all the cases which they study with medical students, that the student is forced to recognize the inseparableness of the medical and social elements in disease.

Since he became dean of the Indiana School of Medicine, Dr. Charles P. Emerson has made a very significant effort to teach students the relation between medical and social conditions. A medical clinic held each week in the Medical School in Indianapolis is followed by a social conference which is often as interesting to the students as any part of their technical training. The social service department of the dispensary in which the medical students have clinical experience is affiliated with the department of sociology of Indiana University. Medical students offer their services to the social worker in cases in which medical-social tangles need to be followed and unraveled. One Tuesday morning the conference discussed a victim of chlorosis, for whom little was done medically beyond the ordering of iron pills. The student who offered to undertake the supervision of this patient's treatment found the girl working in a laundry where she was standing all day on a wet floor and feeding wet clothes into the mangle. She took a cold lunch to the laundry, and outside

of working hours helped with the housework at home. She slept with her grandmother, who had a prejudice against "night air."

The discussion of such a case as this impresses upon the student, as no textbook can, the futility of medical unrelated to social treatment. While supervising the medical care of the case, the student's experience constantly teaches him the medical and social inter-relations in the causation, the prognosis, and the cure of disease.*

Social service departments in hospitals or dispensaries affiliated with medical schools have a unique opportunity to bring clearly before students the inevitable complexity of the patient's physical, mental, and social conditions. It is important to relate instruction in the mental and social elements of a patient's condition very closely to the clinical consideration of his disease. By making use of clinical material as an avenue to a broadening of the student's outlook on medicine, it is possible not only to teach him to be a better physician but also to recognize some of his own relations to the community's health agencies. If while he was following the treatment of a case of typhoid, he could at the same time know the trail to the source of the patient's infection, his eyes could possibly be opened to the importance of a pure milk supply and some of the functions of the board of health. Medical-social workers can do a great service in revealing to

* For list of diseases and the social treatment which they demand, see Appendix, p. 240.

socially-minded medical students the opportunities and responsibilities in their most human profession.

HOSPITAL SOCIAL SERVICE AND THE NURSE. The social worker in the hospital can often bring to the attention of the pupil nurses interesting social facts about the patients for whom they are caring. She may help the nurse to be conscious of the individuality of the patient in the rush of hospital life, and to keep clearly before her the patient's need of occupation and recreation, the anxious family outside, the employer, and the many other human aspects of her work.

Up to the present time hospital social service has had little effect on the training of the nurse. She has been disciplined for skilled bedside care of patients. Her hands have been trained for delicate service to suffering bodies; her mind taught to recognize general symptoms in the progress of disease. The demand for this type of nurse will never cease. But the field of usefulness for women with medical and nursing training has greatly broadened in recent years. Other types of nurses are also in demand now—nurses to serve in various kinds of public health work. The training schools are not fitted to prepare women for this variety of special functions. The great army of nurses, who for many years have been serving in such public health movements as factory nursing, visiting nursing, tuberculosis campaigns, insurance

work, prenatal work, the infant mortality fight, the prevention of blindness, and the intensive health work of social settlements, have had little preparation for their tasks except a general medical training within the hospital walls. Individual nurses have entered public health work because of their social interests. But their special skill has come through experience in their chosen sphere rather than in formal preparation. Practical experience should not be underestimated, but more consistent training is now in demand.

Within the last few years, the schools of philanthropy in New York, Chicago, St. Louis, and Boston have enrolled an increasing number of nurses as pupils. A few schools for visiting nursing have developed, such as those in Boston and Cleveland. Courses in public health nursing are now offered at the Teachers College, New York, under the Department of Nursing and Health and by the Boston School for Social Workers in affiliation with the Instructive District Nursing Association. But only a very small proportion of the nurses now in public health work have had the advantages of any of these courses. Nor can the nurses who have had these opportunities begin to meet the demand for socially trained nurses.

The nurses' training schools have found it impossible to adapt the technical training of the nurse to the phenomenal development of the field of usefulness now open to her. Some of the training schools, however, have made it possible for

the pupil nurses to leaven their three years of hospital routine with a short experience in visiting nursing. The object is usually two-fold: to broaden the outlook of the nurse by bringing to her attention the conditions under which her patients live; and to give her an opportunity to see the function of the nurse in the homes of those who are both sick and poor. In the Presbyterian Hospital, New York, many of the nurses, during their third year, elect a period of visiting nursing under the direction of the supervisor of visiting nursing connected with the hospital. Other training schools have arranged with visiting nursing associations to give undergraduates two or three months' experience, under the supervision of the association.

In hospitals with well-organized social service departments, an opportunity might be offered for nurses who desire it, to secure experience in hospital social service. The time that could be allowed for such experience would undoubtedly be too short for thorough training but it would give the nurses an acquaintance with the attractive openings in this new field. Also, the undergraduate nurse might get an insight into visiting nursing, school and factory nursing, baby hygiene work, tuberculosis, and medical educational work, under the guidance of the social service department of the hospital. Such experience could not fail to broaden her outlook, whatever kind of nursing she does after graduation. Such a curriculum would in-

dicate the rapidly developing fields of usefulness for nurses and might attract to the training schools an increasing number of women of superior ability and education.

Such a plan of co-operation has been started at the Massachusetts General Hospital. Senior nurses who have a special social interest are permitted to have three months' experience in the social service department. No nursing is done during that time, but the nurse becomes a social student-worker in the department, studies the patients, and is shown the close relation of the medical service that the hospital is rendering and the efforts of the social workers. One of the pupil nurses who had this experience testified that not only her social but her *medical* knowledge increased in this period because many patients and diseases treated in the out-patient department were not admitted to the ward and so never seen by the nurses. The variety of experience and the awakening of the nurse to the activities for social betterment give her not only a glimpse of a new field open to her if she feels called to that type of service, but further make her more conscious of what is going on in the world about her so that "even the newspapers are more interesting."

HOSPITAL SOCIAL SERVICE AND THE SOCIAL WORKER. Possibly no one has welcomed the hospital social worker more heartily than the social worker outside the hospital. Except for an oc-

casional fear that the hospital worker might trespass on the province of the other social workers, there has been a general recognition of the openings in this new field and an appreciation of the help which the social worker within the hospital might give to those without. She can interpret to the worker outside the technical and cryptic information given out by the physicians about the patients sent to the dispensary clinics; she can also advise the outside worker as to the needs of the patients discharged from the wards. Such knowledge as she can give is often necessary to a constructive plan for the man seeking charitable assistance.*

Acquaintance with the relation of disease to dependence is not new to social workers, but they need much more definite knowledge of physical conditions. Also from the doctor they have much to learn concerning the subtler relations between sociological and physical sufferings. What the hospital social workers thus learn they can pass on to the social workers outside. Such an exchange enlarges the community's understanding of the influence of sickness on character, of the pathological effects of fatigue and malnutrition, of the preventive and curative use of hygienic measures, of the value of suitable diet and the limitations of moral responsibility in the victims of wretched physique. In the future there will be fewer failures in plans for the socially afflicted which can be traced to ignorance of the physical background.

* See Chapter IV, p. 97.

In some cases the physical basis, all ignored, may be the chief cause for the individual disaster. An illustration of this truth is given in the fourth annual report of the social work at the Massachusetts Charitable Eye and Ear Infirmary, Boston. The report reads, "A man, forty-eight years of age, was sent to us one day, ragged, emaciated, almost helpless without his glasses, which had been broken a few days before. His record with the public and private charities of Boston and other cities was a very bad one: idleness, drink, immorality, neglect of his children. The hospital found a condition of high myopia, which had been corrected only after the man had passed his twenty-fifth year, when he had thoroughly learned the lesson of idleness; the rest had followed easily. All his life he had been handicapped; in school, when his fellow-pupils who had better vision left him far behind; later, when work was difficult to find and, for him, almost impossible to keep; and later still, after glasses had been found to help the vision, by the habit of idleness and its attendant evils acquired through little fault of his own. There was no doubt about his very bad record, but the hospital finding left much doubt as to his individual responsibility for it. Though our report could, of course, make no difference in the action of any charitable society in such a case, as present conditions must govern action, it would essentially change the attitude and modify the message to the public in regard to this physical misfit."

Sometimes return to health brings about transformations in character that are unpredictable. A change of heart, no less startling than conversion, followed the amputation of a foot which the doctors had fought for months to save. The victim had been irritable, neglectful of his children, and given to drunken sprees. Convalescence after the operation found him changed to a sober, hard-working man.

Many years ago, Florence Nightingale said that there could be no health of the community without health of the individual. The most fundamental means of securing health for people is education. Physicians are increasingly convinced that the best relationship for treatment of a patient is one of frankness and mutual trust. The patient with tuberculosis now knows his condition and becomes a partner in treatment. There is gradually developing a belief that the best remedy for the little knowledge that is a dangerous thing is more knowledge. Broad-minded men and women in the professions of medicine and social work have seen that dissemination of medical knowledge is on the whole a safeguard, not a danger; and that education in physiology and hygiene is among the most important factors for community health.

Hospital social service offers one of the best opportunities for general and individual education in hygiene and right living. The opportunity to interpret daily physical facts to social workers outside the hospital, to point out social facts to

physicians, and to explain simple laws of wholesome living to patients, makes the hospital social worker rejoice that any knowledge she may have is not held secret in her profession. Her greatest privilege is to pass it on truthfully and generously to others.

APPENDIX

FORMS AND FACSIMILES

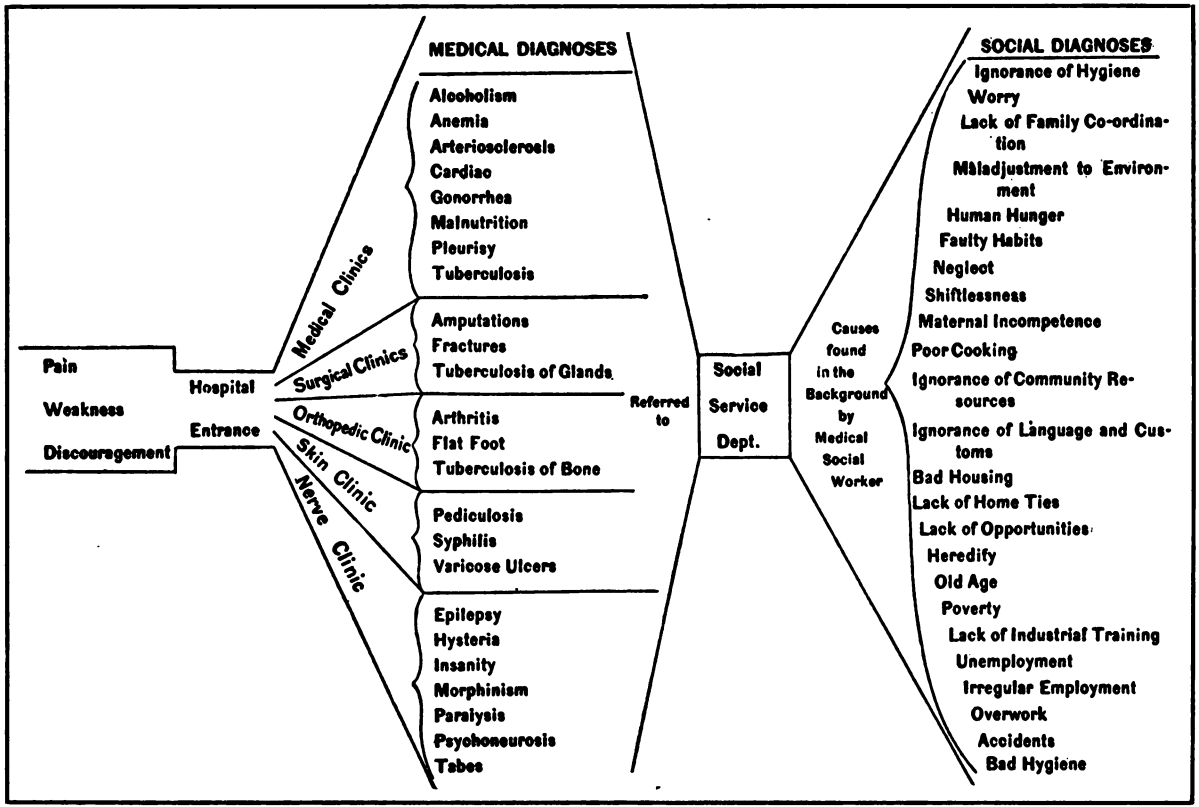


DIAGRAM SHOWING THE RELATION OF MEDICAL AND SOCIAL CONDITIONS AS FOUND BY THE HOSPITAL SOCIAL WORKER

From the 4th Annual Report, Social Service Dept., Mass. General Hospital

Massachusetts General Hospital—Social Service Department

Referred by Society for Prevention of Cruelty to Children, Beverly Date July 13, 1912.

Name Harry Elmore

Address 25 Cross St., Beverly S. M. W. D. Age 39

Nationality American

Birthplace Beverly

Previous medical treatment (place): (When)
Dr. Allen, Private physician - last winter
Beverly Hospital, Dec. 5, 1911 - 3 weeks

Significant facts in family history—physical and social:
Uncle epileptic, feeble minded, epilepsy in wife's family; wife high-strung, neurotic; son Ralph, 14 yrs, wayward, untruthful, ran away from home Intermittent relief case.

Significant facts in patient's history—physical and social:
Family physician says diagnosis last winter, "physical exhaustion" for want of better term Beverly Hospital diagnosis "debility" last winter. Man so sick has had to give up work at times and go to bed Worried about financial condition and conduct of son

Employment

Nature Factory Hand Place United Shoe Machinery Co, Beverly Hours 51 hrs. wk

Reason for referring:
Is man able to work? Does he need hospital or convalescent care?

To the Clinic Physician:

The Social Service Department respectfully requests the following information:

Diagnosis Possibly tuberculosis - To be investigated further.

Prognosis Cannot give prognosis until diagnosis decided upon.

Suggestions (wherein Social Service or referring agency may co-operate):
This pt. has signs of a possible tuberculosis and must return with sputum and for further observation. Can you keep track of him and put the Beverly Charities on his trail if in two weeks he has not returned to us?

FORM USED BY AGENCIES REFERRING PATIENTS TO DISPENSARIES FOR REPORT OF PHYSICAL CONDITIONS THROUGH A SOCIAL SERVICE DEPARTMENT

BOSTON DISPENSARY **SOCIAL SERVICE DEPARTMENT**

Referred by Associated Charities **Date** Nov-14-1912

Fees to be remitted · Yes ~~No~~

Name Tony D. G. S. ~~M. W. D.~~ **Age** 13

Address 70 Unity Court, City **Nationality** Sicilian

How long in U. S. A. 5 yrs

Faith Roman Catholic " " " Boston 5 yrs

Employment **Hours Daily**

Nature hour at present. Formerly **Place** In Father's Cobbler Shop
School 1st Grade

Significant Facts in Family History. Physical and Social.

Eldest of ten children, of whom nine are living. Sisters 13, now in Holy Ghost Hospital recovering from tbc of lungs and glands of neck. Next to yng bt Childrens Hospital, rickets. Baby of 14 mo. died in June of Spinal meningitis. 6 other children unaffected.

Health Record of Patient

Probably good. He tells of Eruptions since left to present one, occurring a year ago.

Previous Medical Treatment. *Places and Dates*

None -

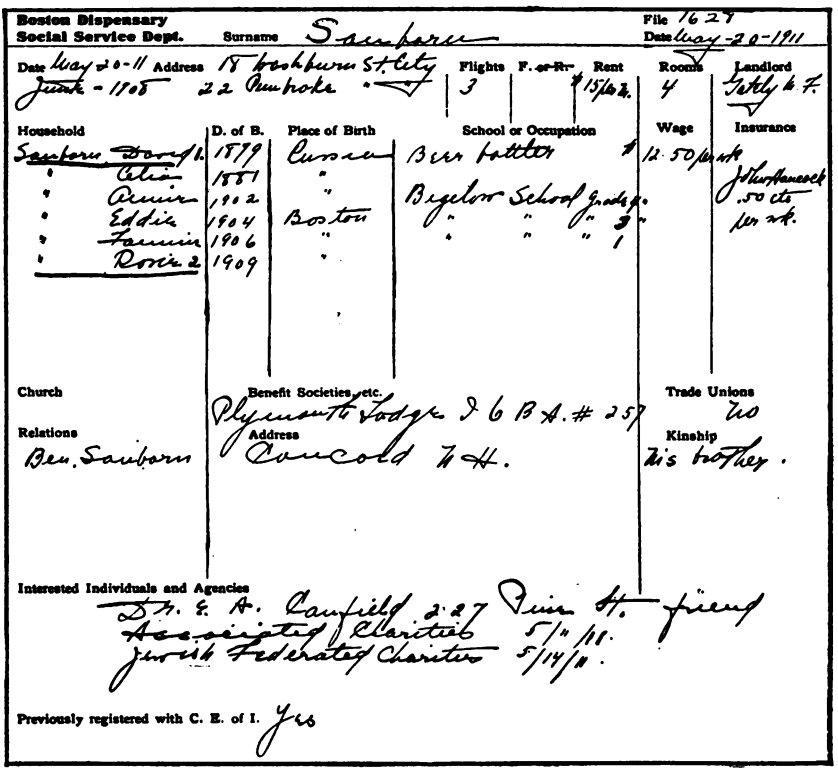
Reasons for Referring

For such medical treatment as is needed, and a report of doctors instructions.

FORM USED BY AGENCIES REFERRING PATIENTS TO DISPENSARIES FOR REPORT OF PHYSICAL CONDITIONS THROUGH A SOCIAL SERVICE DEPARTMENT

Number persons	Family group	Ages	Diagnoses																						No. of visits to Various Clinics							Total no. of visits to O.P.D.	Cost to O.P.D. @ 45¢ per visit	No. of prescriptions	Cost of prescriptions	No. days in Hospital	Cost to Hosp. @ $2.52 per day	Total cost per patient
			Syphilis	? Syphilis	Specific Parotitis	Scabies	Pediculosis	Urticaria	Eczema	Tonsilitis	Bronchitis	Constipation	Gingivitis	Sclera-Derma	Bleph. Conjunctivitis	Ichthyosis	Stomatitis	Phlyct. Keratitis	Adenoids & Tonsils	Rhinitis	Septic Thumb	Varicose Veins	Chronic Metritis	Cystic Degen. of Ovaries	Skin	Children's	Female Medical	Female Surgical	Orthopedic	Nerve	Throat							
1	fa	42		v		v																			2					1		2	$ .90	1	$ .15			$ 1.05
2	mo	40	v			v	v														v	v	v	v	27		2	2	2			29	13.05	31	8.05	28	$ 70.56	91.66
3	da	14				v	v	v																	3							3	1.35	5	.35			2.20
4	da	13				v	v								v					v					7	2	1					9	4.05	6	1.55			5.60
5	da	12		v		v	v					v													6	6						8	7.20	8	2.05			9.25
6	s.	12	v			v			v																2[illegible]						1	29	12.60	24	6.20	21	52.92	71.72
7	da	11		v	v	v	v											v							9							9	4.05	5	1.15			5.20
8	da	10				v		v						v		v									8	2						10	4.50	7	1.05	22	55.44	60.99
9	da	6				v																			1				1			1	.45					.45
10	da	3				v	v	v		v	v	v	v				v		v						4	2						5	2.25	8	1.65			3.90
11	s.	3				v	v	v																	6							5	2.25	6	1.00			3.25
Totals			2	3	1	11	7	4	1	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1	102	12	3	2	3	1	1	110	$52.65	101	$23.70	71	$178.92	$255.27

Analysis of the Hospital Expense Involved in Free Treatment of a Family of Eleven Coming to the Hospital for a Period of Three Years



Boston Dispensary
Social Service Dept.

Surname Sanborn — File 1627 — Date May-20-1911

Date May 20-11 — Address 18 Washburn St. City — Flights 3 — F. or Rr. — Rent $15/00 — Rooms 4 — Landlord Getty & F.

Household	D. of B.	Place of Birth	School or Occupation	Wage	Insurance
Sanborn Wm. H.	1879	Russia	Ben Tailor	$12.50 per wk	
" Celia	1881	"			John Hancock .50 cts per wk.
" Annie	1902	"	Bigelow School Grade 6		
" Eddie	1904	Boston	" " " 3		
" Fannie	1906	"	" " " 1		
" Rosie 2	1909	"			

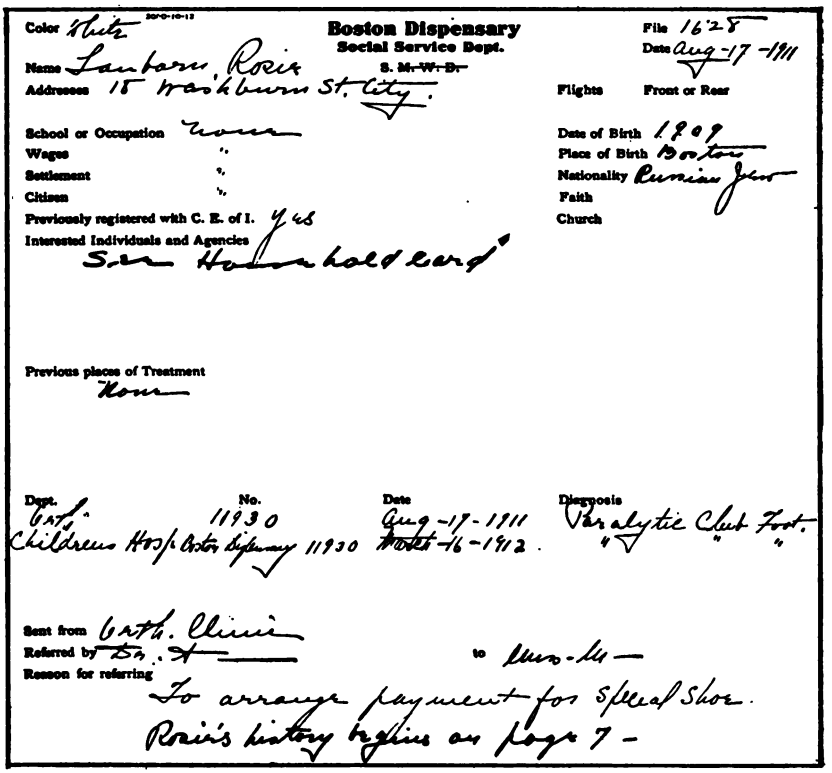
Church — Benefit Societies, etc. Plymouth Lodge I O B A. # 257 — Trade Unions 210

Relations Ben. Sanborn — Address Concord N.H. — Kinship his brother.

Interested Individuals and Agencies
Dr. E. A. Canfield 227 Main St. friend
Associated Charities 5/11/11.
Jewish Federated Charities 5/14/11.

Previously registered with C. E. of I. Yes

FAMILY RECORD CARD. SOCIAL SERVICE DEPARTMENT, BOSTON DISPENSARY



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Boston Dispensary
Social Service Dept.
~~S. M. W. D.~~

File 1628
Date Aug-17-1911

Name Lantara, Rosa
Address 15 Washburn St. City.

Flights Front or Rear

School or Occupation None
Wages "
Settlement "
Citizen "
Previously registered with C. E. of I. Yes

Date of Birth 1909
Place of Birth Boston
Nationality Russian Jew
Faith
Church

Interested Individuals and Agencies
See Household card

Previous places of Treatment
None

Dept.	No.	Date	Diagnosis
Orth. Children Hos/ Boston Dispensary	11930 11930	Aug-17-1911 Mch-16-1912.	Paralytic Club Foot. " "

Sent from Orth. Clinic
Referred by Dr. H ——— to Mrs. M ———
Reason for referring To arrange payment for special shoe.
Rosa's history begins on page 7 -

INDIVIDUAL RECORD CARD, FOLLOWING FAMILY RECORD CARD. SOCIAL SERVICE DEPARTMENT, BOSTON DISPENSARY

HOSPITAL UNIVERSITY OF PENNSYLVANIA

Social Service Department

Name	**Age**	**S. M. W. D. Case No.**
		Date of Birth
		Place
		Nationality
Address		**Church**
Former Address	**Citizen**	**How long in U. S.**

Occupation **Industry**

Sick Benefits, Insurance, etc.

Wages

Household	Age	Occupation	Wage	Health

Relatives	Address	Kinship

Rent **Condition of House**

B. of R. **Interested Individuals and Agencies**

Family Physician

Previous Places of Treatment

Sent From **Date Referred**

Diagnosis (Date)

Referred by **To**

Reason Referred

RECORD FORM USED BY SOCIAL SERVICE DEPARTMENT, UNIVERSITY OF PENNSYLVANIA HOSPITAL

4-140-12 (B) 15,000

SOCIAL SERVICE BUREAU

BELLEVUE AND ALLIED HOSPITALS

Ward 0 Clinic

Name Santo, Marie

Residence Thompson St.

Care of Floor ~~Apt.~~ 2d

Admitted Previously Treated no

Age 19 ~~Mos.~~ Yrs. Cath. ~~Prot. Heb.~~

Single ~~Married~~ ~~Widowed~~ ~~Separated~~

Nativity Italy In U. S. In City 7 yrs.

Occupation Button-hole Worker Earnings $6 Wk. ~~Mo.~~

Unemployed 3 days

Friend Guido J.

Address Baxter St. Telephone

Brought ~~by~~ from H. St. Hospital

Ambulance Surgeon Smith

Officer Brown Prec. 8th Court 1st

Charged with Attempted Suicide

Diagnosis Hysteria Disch.

Husband's or Wife's Name	Address	Occupation	Earnings ~~Wk.~~ Mo.
Father's and Step Mother's Names			
Salvatore	Thompson St.	Barber	$15.
Annie			
~~Brothers' or~~ Sisters' ~~or Children's~~ Names	Age		
Carmen	12 yrs.	(In Italy with grandparents)	

No. Dependent Ages Yrs. Yrs. Yrs. Mos.

Rent $12. No. Rooms 3 Sanitary Condition fair

Previous Residence Greenwich St.

Other Income—Boarders Lodgers Benefit Societies

Known to following Relief Agencies

Need Investigation. Friendly advice.

Referred by Prison Ward Blotter Date

C. DeW. W. S. S. Worker.

RECORD FORM USED BY SOCIAL SERVICE BUREAU, BELLEVUE AND ALLIED HOSPITALS (FACE)

PINK	LIGHT BLUE Unmarried Mothers	LIGHT BROWN Family Destitution	YELLOW Loan	LIGHT GREEN Conval. Home	SIGNAL CODE OLIVE Private Perm. Home	SIGNAL CODE VIOLET Deport. Transport	SIGNAL CODE RED Employment	SIGNAL CODE BLACK Clothing	DARK BLUE Homeless	DARK GREEN Boy	ORANGE Drug Drinking Habit	BLACK & BROWN Prisoner	RED & OLIVE Suicide	PLAID

Disposition of Case

Referred to (Other Agency) A. S. C. W. Date

Convalescent Home Date Referred

No Vacancy Declined to go Rejected Date Admitted

Permanent Home Public, Private, Semi-Private Date Referred

No Vacancy Declined to go Rejected Date Admitted

Employment Suggested Secured Not Secured

Loan With Power of Attorney, Returned Without Power of Attorney, Returned

Referred to Probation Officer Free Legal Aid

Accompanied to Train, Home, Court, Date Home Instruction in Hygiene

Referred for Deportation, Transportation to Date Deported, Transported, Date

Emergency Aid by Temporary Lodging, Meals, Clothing, Carfare, Telephone, Messages to Friends, Special Information, Advice, Letters,

Transportation Exchange of S. S. Tickets, Surgical Appliances

NOTE

RECORD FORM USED BY SOCIAL SERVICE BUREAU, BELLEVUE AND ALLIED HOSPITALS (REVERSE)

Name Smith. Henry John Age 28 S. M. W. Case No. 6669.

Address 100 Melrose St. Malden Flights 0 How long there? 2 yrs.

Previous address 237 Pendleton Ave " How long there? 1 1/2 yrs.

Date of birth July 9. 1884

How long in U. S.? Life Place " " Malden

" " " Malden "

Nationality English American.

Citizen Yes Settlement Malden Church 0

Occupation Reamer in Rendering Dept. Wages $3 per day when work Rent $12 per month

Industry Steel Works. Insurance No

Names of Relatives	Kin.	Age	Birthplace	Wage	Address	O. P. D. No.	S. S. D. No.
Mary King	wife	28	Newton		As above		
Lawrence	Son	5	Malden		"		
James	"	4	"		"		
Howard	"	1½	"		"		
Minnie	Dau.	3	"		"		
Lawrence	Father	49	England	$3 per day	45 Glendale St. Malden		
Minnie Bell	Mother	48	Mass.		"		
Howard (s)	Bro.	17	Malden	?	?		
Arthur	"	10	"		As above		
Mabel Murray	Sister	21	"		Sarin Hill St. Lynn		
Sylvia	"	14	"		45 Glendale St. Malden		
Sarah	"	12	"		"		

Interested Individuals and Agencies Paul Brown. Agent O. of P. (Letter) Relief Association. Malden. Miss Thompson agent.

Registered previously with C. E. of I. No

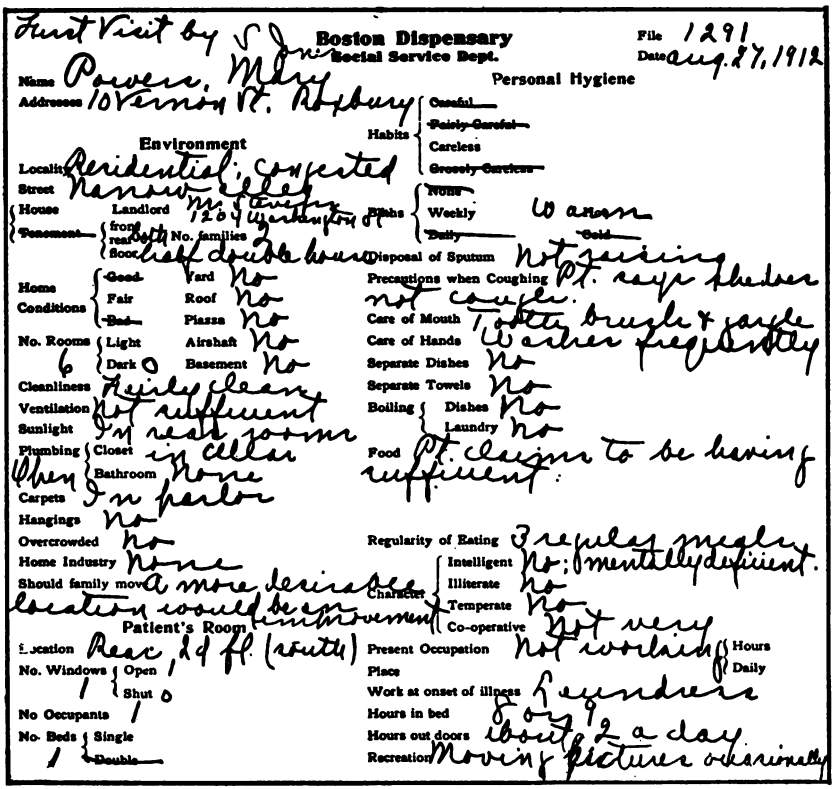
O. P. D. No. 20391 Sent from Orthopedic First visit to O. P. D. Sept. 14 '12

Medical Diagnosis Ptosis of Stomach Phthisis Nov. '12 Date referred to S. S. D. Oct. 26 '12

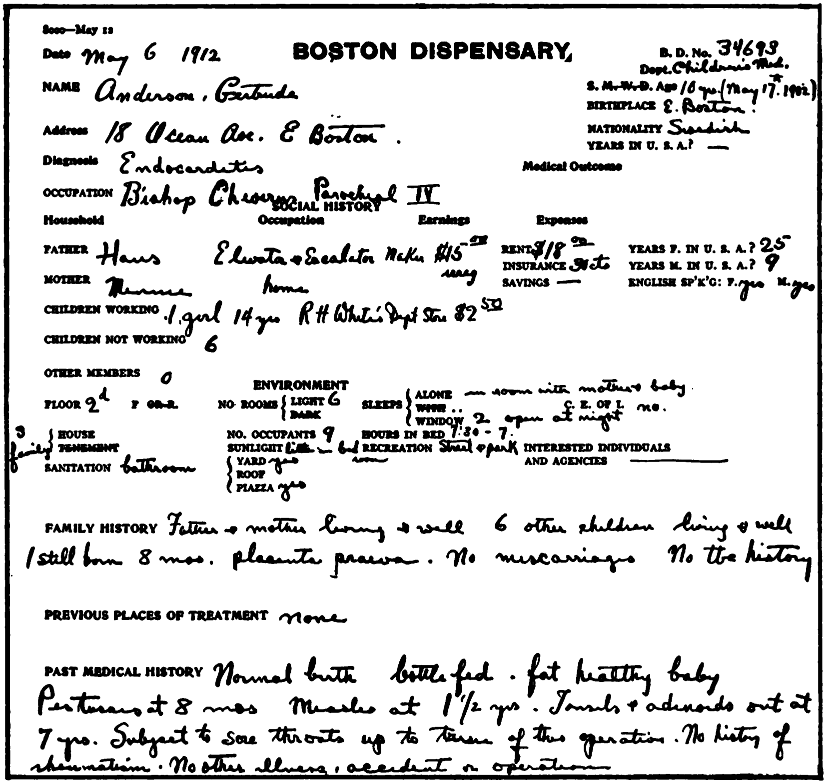
Referred by Dr Tompkins

Why? Anterior - Posterior Pad
28 in upper
32 in Lower

Social Diagnosis



RECORD FORM USED FOR TUBERCULAR PATIENTS. SOCIAL SERVICE DEPARTMENT, BOSTON DISPENSARY



5000—May 12

Date May 6 1912 **BOSTON DISPENSARY** B. D. No. 34693

Dept. Children's Med.

NAME Anderson, Gertrude S. M. W. D. Age 10 yrs (May 17. 1902)

BIRTHPLACE E. Boston.

Address 18 Ocean Ave. E Boston. NATIONALITY Swedish

YEARS IN U. S. A.? —

Diagnosis Endocarditis Medical Outcome

OCCUPATION Bishop Cheverus Parochial IV

SOCIAL HISTORY

Household	Occupation	Earnings	Expenses	
FATHER Hans	Elevator & Escalator Maker	$15.00 away	RENT $18.00 INSURANCE 30 cts SAVINGS —	YEARS F. IN U. S. A.? 25 YEARS M. IN U. S. A.? 9 ENGLISH SP'K'G: F. yes M. yes
MOTHER Minnie	home			

CHILDREN WORKING 1 girl 14 yrs R H White's Dept Store $2.50

CHILDREN NOT WORKING 6

OTHER MEMBERS 0

ENVIRONMENT

FLOOR 2d F OR R. NO. ROOMS { LIGHT 6 DARK } SLEEPS { ALONE — room with mother & baby WITH .. WINDOW 2 open at night } C. E. OF I. no.

3 family { HOUSE TENEMENT } NO. OCCUPANTS 9 HOURS IN BED 7:30 - 7.

SANITATION bathroom SUNLIGHT little — bad RECREATION Street & park INTERESTED INDIVIDUALS AND AGENCIES ——

{ YARD yes ROOF PIAZZA yes }

FAMILY HISTORY Father & mother living & well 6 other children living & well 1 still born 8 mos. placenta praevia. No miscarriages No tbc history

PREVIOUS PLACES OF TREATMENT None

PAST MEDICAL HISTORY Normal birth bottle fed. fat healthy baby Pertussis at 8 mos Measles at 1½ yrs. Tonsils & adenoids out at 7 yrs. Subject to sore throats up to time of this operation. No history of rheumatism. No other illness, accident or operation

RECORD FORM USED FOR ALL MEDICAL HISTORIES IN THE CHILDREN'S CLINIC, BOSTON DISPENSARY

BOSTON DISPENSARY CHILDREN'S HOSPITAL

WARD RECORD

Name Mary----
Age 8½ months
Birthplace

Hospital No. 857
Out-Patient No. 25766
Social Service No. 2379

Parents' Name George & Fanny
Parents' Address 23 Ingleside Street, Roxbury

Admission Date March 18, 1912
Admission Diagnosis Burn on foot

Discharge Date March 25, 1912
Discharge Diagnosis Cured

Prognosis

Complications

(Family, Social and Personal History, Physical Ex. etc.)

FAMILY HISTORY: Father alive and well; mother, phlebitis since last summer, and nervous prostration. Miscarriage due to hard work. Twins died at birth. One brother and three sisters alive and well.
SOCIAL HISTORY: Family are Irish Catholics who came from N--2 ago. Father was a councilman and ran small store; failed in Nov. 1911. Wife then ill in hospital when last child was born. In January parents broke up home, sent older children to relatives and placed baby in St. Mary's Infant Asylum, where it later was boarded out. Parents secured position temporarily as house-keeper for a family in D--. They have their board (and that is all) in return for service given. Asso. Charities interested in helping family and will place baby to board when discharged from the Hospital. Mrs., at present, being treated in Disp. Diagnosis, ? Specific. Family also known to A.C. of D. Family unable to pay hospital fee.
PAST HISTORY: Normal delivery; 8 mos. gestation. Ophthalmia at birth. Breast for 3 weeks; since then has been in various institutions and boarded out. Feedings while boarded, unknown. Has had some cough. Bowels regular. Eats well. Does not sleep well. Has been fed from our O.P.D. past two weeks.
PRESENT ILLNESS: Mother burned baby's foot with hot iron while trying to warm it; burned 16 days ago. Burn has not done well on home treatment. Has had Mead's 3 6.5 1.5 B.S.. 75 LW 20% m&c. F7 oz.7. Has vomited a little after feeding.

PHYSICAL EXAMINATION:

FINAL DISPOSITION: Medical: Mary discharged to Mass. Babies' Hospital for boarding, pending parents' arrangement for housekeeping.
Social: Referred to Asso. Charities, dist. 4, to aid family, who sent mother and children to parents in Maine for 3 months. Father started a store and is getting on.

WARD RECORD. CHILDREN'S HOSPITAL, BOSTON DISPENSARY

REFERRED TO SOCIAL SERVICE DEPT

BY DR. Lee

Reason referred (*i. e.* what does the patient need?)

Patient has been "fluttering around" In my opinion she has definite tuberculosis (slight) She needs an iron hand & sanatorium treatment.

Roger S. Lee.

REFERRED TO SOCIAL SERVICE DEPT.

BY DR. Waterman

Reason referred (*i. e.* what does the patient need?)

This patient tells us stories of abuse at home by his sons. He is depressed and moody. Can you tell us what the conditions are there?

REFERRED TO SOCIAL SERVICE DEPT.

BY DR. Badger

Reason referred (*i. e.* what does the patient need?)

She is overworked, and tired, works all day in a candy store, and at home nights. Can you arrange for her a better day? She needs help. Do not definitely tuberculous, but will report to us from time to time for further examination.

REFERRED TO SOCIAL SERVICE DEPT

BY DR. Mead

Reason referred (*i. e.* what does the patient need?)

Annie Kann needs a corset but says she is unable to pay for it. It was recommended for her 2 years ago. She never has had money enough to get it. I imagine her husband needs bracing up.

Form 264

Massachusetts General Hospital.

Leave on Admitting Physician's desk.

To ..... Executive Assistant

Tony Catello of Ward H (Service)

is referred to you for

(Underline the following to be looked up)

Removal to another institution

Investigation of home conditions.

" " financial condition.

Apparatus.

Ward visiting for .....

.....

Diagnosis Lobar pneumonia, Anaemia T. 13

Prognosis Good

Future treatment

How long will aid be required ?

Patient will be ready for discharge in one week

(Probable date)

Remarks .....

Father "sick" — has one in family working

Dec. 1

1912

.....

House Pupil.

FACSIMILE OF REFERENCE SLIP USED BY PHYSICIAN REFERRING PATIENT TO A SOCIAL WORKER

BOSTON DISPENSARY

Page 1 Record No.

NAME Age S. M. W D. Date 191

Address Color B. D. No.

Clinic { Old patient / Dates and clinics

Nationality Birthplace

Names of parents (or husband)

How long resident of U. S. A.

How long resident of Boston Yrs. Mos.

OCCUPATION Earnings

Position

Where employed

How long in present occupation Previous occupations

NARRATIVE *(based on interview at desk) Bring out following points*

Patient's attitude toward Dispensary
What sent patient to Dispensary
Previous usual medical resource
O. P. D. (Where and for what)
Hospital (Ditto)
Private Doctor (G. P or Sp'l't)

FORM USED FOR STUDY OF GROUP OF PATIENTS COMING TO THE BOSTON DISPENSARY (FACE)

BOSTON DISPENSARY

Page 2 Record No.

HOME H. or T. Floor F. or R. Rooms Occupants Rent, $ per wk.

Light Air Clean Tidy Sanitation

Sunlight Windows face on

Housing summary

HOUSEHOLD

No.	Name	Date Birth	Place Birth	Occupation and Earnings

CHARITY Were B. D. fees paid Known C. E. of I.

Interested agencies

Financial aid

DIAGNOSIS as on record

Prescription as on record Referred to S. S.

Treatment program as on record

Medical outcome as shown on record

FORM USED FOR STUDY OF GROUP OF PATIENTS COMING TO THE BOSTON DISPENSARY (REVERSE)

Boston Dispensary

EFFICIENCY TEST IN ..... DEPARTMENT

for months of _____ 191

Diagnoses Tabulated .....

Visits per Patient	MEDICAL RESULTS							Total Number of Cases	
	Continued Treatment, discharged cured	Continued Treatment, ceased or was discharged improved	Ditto, not improved	Treatment pursued and now continuing	Case transferred to care of another Medical or Social Agency		Result unsatisfactory because patient failed to return for treatment ("Lost Cases")	Medical Outcome Unknown	*Per cent.*
One									
Two									
Three									
Four									
Five									
Six to Eight									
Nine to Twelve									
Over Twelve									
Totals									
Percentages									

SURVEY — CHILDREN'S CLINIC

Name Age Sex O. P D. No.

Residence Birthplace

Diagnoses (dates, if noted)

Date of 1st visit (Children's Clinic) Date of latest visit (Ch. Cl.) Total No. visits

Ref. from	Clinic	Date	No. visits
" to	"	"	" "
Trans. from	"	"	" "
" to	"	"	" "

Other clinics dealing with child April 1st

" " " " " August 1st

Condition as noted on latest visit to Ch. Rm. (Rpt. to Aug. 1st)

RESULTS UNSATISFACTORY

Pt. attending regularly, but no results

" failing to attend

Any note on record of advice to return?

RESULTS SATISFACTORY

Treatment followed: Pt. improved

" " " cured

LABORATORY TEST

Urine analysis

Sputum

Blood

Stool

Wasserman

Vaginal Smear

Cases pending, Aug. 1st

Pt. ref. to House Date Diag Cond. on disch.

Asked to rpt. at O. P. D.? Reported? Date

Referred to other institution

Social Record

FORM USED FOR SURVEY OF MEDICAL RECORDS OF CHILDREN'S CLINIC, MASSACHUSETTS GENERAL HOSPITAL

DISEASES and the SOCIAL TREATMENT Which They Demand.

	Support for Patient or Family.	Prevention of Contagion and Discovery of Cases in House.	Advice and Guidance in Plan and Place of Treatment, Including Institutions.	Help in Finding or Changing Work.	Persuasion, Encouragement, Consolation, Training.	Nutrition and Hygiene of Person and Home.	Home Nursing.
Tuberculosis	*	*	*	+	+	+	*
Typhoid	*	+	....	+	.....	+	.....
Syphilis	†	*	*	.....	+	+	.....
Sepsis (local especially)	†	.....	.....	.....	.....	*	+
Gonorrhœa	.....	*	‡	.....	+	+	.....
Infectious Enteritis	.....	+	*	.....	.....	+	*
Infantile Paralysis	.....	+	+	*	.....	.....	.....
Pneumonia	+	.....	.....	.....	.....	.....	+
Epidemic Meningitis	.....	+	.....	.....	.....	.....	+
Appendicitis	+	.....	.....	....	.....	.....	.....
Trichiniasis	+	+	....	.....	.....	+	.....
Pediculosis, Scabies, Favus (contagious, local), etc.	.....	*	+	.....	.....	+	+
Alcoholism and Morphine	*	.....	+	+	*	+	.....
Industrial Diseases and Neuroses	+	.....	+	*	+	+	.....
Diabetes	+	.....	+	.....	+	*	.....
Rickets	.....	+	+	....	.....	*	.....
Heart Disease	*	.....	+	*	+	+	+
Bright's Disease	*	.....	.....	.....	+	.....	+
Chronic Joints	+	.....	+	*	*	+	.....
Cancer	*	.....	*	.....	+	.....	+
Organic Nerve Disease	*	.....	*	+	+	.....	+
Insanity, Feeble-mindedness	+	.....	*	.....	.....	.....	.....
Functional Nervous Disease	+	.....	+	+	*	+	.....
Chorea	.....	.....	+	.....	.....	+	*
Varicose Ulcer	.....	.....	+	+	*	.....	+
Fractures	*	.....	.....	*	+	.....	.....

*Of Special Importance †Sometimes. ‡In Vaginitis Especially

18

LIST OF DISEASES AND SOCIAL TREATMENT WHICH THEY DEMAND

From 7th Annual Report, Social Service Dept., Mass. General Hospital

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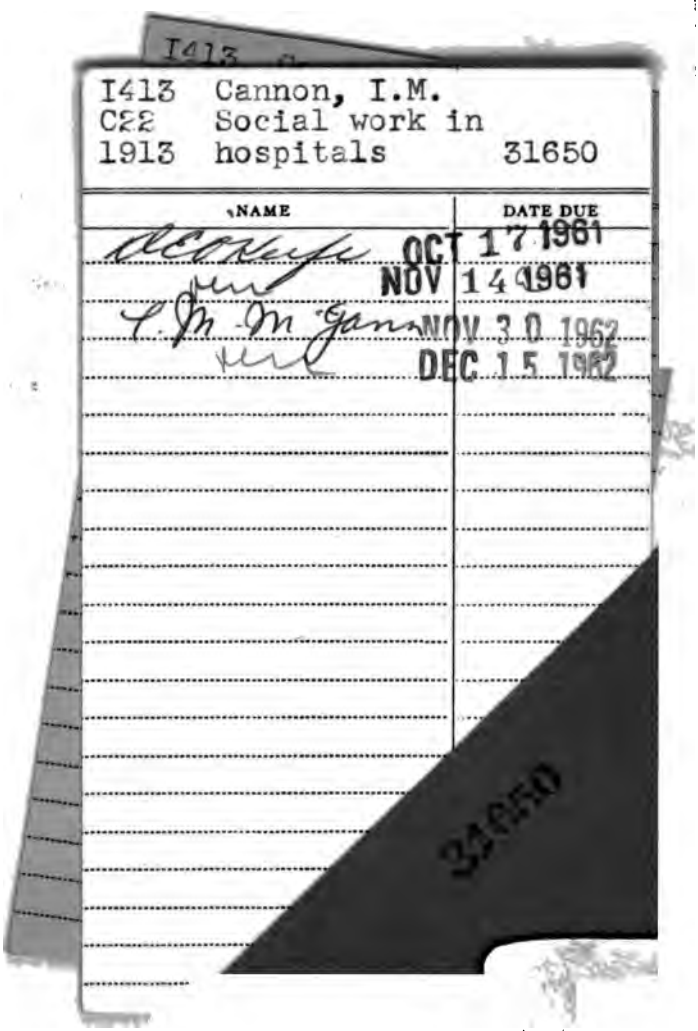

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